CHILDREN FIRST MEDICAL GROUP, INC.

PROVIDER MANUAL
JANUARY 2022

CHILDREN FIRST MEDICAL GROUP

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Introduction

Welcome to Children First Medical Group, Inc. (CFMG). We are pleased to have your practice participating in our pediatric network.

CFMG was formed as a comprehensive pediatric medical network, offering primary care and pediatric specialty services for children ranging from birth (newborns) up to twenty-one (21) years of age. CFMG's network consists of both hospital based physicians who practice at UCSF Benioff Children's Hospital Oakland and community based physicians who operate private practices throughout Alameda and Contra Costa counties. CFMG's physician network is currently comprised of 574 physicians, 184 primary care physicians and 390 specialists, who practice in a wide array of pediatric specialties with a majority being board certified in their particular specialty.

CFMG manages approximately 50,000 Medi-Cal members from two established health plans: Alameda Alliance for Health and Anthem Blue Cross.

CFMG also provides the following administrative services: compliance, contracting, credentialing, provider relations, member services, claim processing, utilization management and a dedicated customer service line for provider calls.

This manual is intended to incorporate the statutory, regulatory and contractual requirements imposed by the California Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid Services (CMS) and other medical professional licensing boards.

Providers have the responsibility of ensuring appropriate staff in their organization review and understand the information contained in this manual.

CFMG holds training sessions for its Providers and staff to assist in learning CFMG policies and procedures.

We thank you for your continued participation and providing quality care to your members/patients. If you have questions regarding this manual, please contact Customer Service at **(510) 428-3154**.

CFMG Office Directory

Children First Medical Group, Inc.

6425 Christie Ave., Ste. 110
Emeryville, CA 94608
(510) 428-3443
(510) 450-5668 Fax
Website: www.childrenfirstmedicalgroup.org

CFMG Electronic Payor ID

Our payer # 94321

Submit Paper Professional Claims to:

Children First Medical Group, Inc.
P.O. Box 99680
Emeryville, CA 94662-9680

Customer Service

Main Line . . . . . (510) 428-3154

Utilization Management

Authorizations . . . . . (510) 428-3489
CFMGum@ucsf.edu

Administration

Medical Director Office . . . . . (510) 428-3384

Chief Operating Officer . . . . . (510) 428-3746

Compliance Department

Compliance Supervisor . . . . . (510) 428-3885 ext. 4259

Credentialing Department

Credentialing . . . . . (510) 428-3527
CFMGcredentialing@ucsf.edu

Provider Relations Department

Provider Relations Manager . . . . . (510) 428-3492

CFMG Compliance Program

The mission of Children First Medical Group (CFMG) is to provide quality, cost-effective health care in a positive and productive work environment. In fulfilling this mission, CFMG is dedicated to adhering to the highest ethical standards and recognizes the importance of full compliance with all applicable state and federal laws. Accordingly, the CFMG Board of Directors and management have adopted this Compliance Program.

The Compliance Program is a part of the routine operations of all CFMG corporate functions. CFMG endeavors to communicate to all personnel the intent to comply with all applicable laws.

In addition, the Compliance Program will:

- Review the organization's business activities and consequent legal risks.
- Educate all personnel regarding the Code of Conduct, and compliance requirements and train relevant personnel to conduct their job activities in compliance with state and federal law.
- Implement auditing, monitoring and reporting functions to measure the effectiveness of the Compliance Program and to address problems in an efficient and timely manner.
- Include enforcement and disciplinary components to assure that all personnel take their compliance responsibilities seriously and adhere to all compliance requirements.

Overall responsibility for operation and oversight of the Compliance Program belongs to the CFMG Board of Directors; however, the day-to-day responsibility for operation and oversight of the Compliance Program rests with the Compliance Supervisor, who will have direct access to the CFMG Board of Directors and will make regular reports to the Board or an appropriate committee of the Board on the status of the Compliance Program.

The Board of Directors will have oversight of the following:

- Annual Compliance Training
- Code of Conduct
- Quarterly Issues of Non-Compliance

Should any persons have questions or uncertainties regarding compliance with applicable state or federal law, or any aspect of the Compliance Program, including related policies or procedures they should seek immediate clarification from the Compliance Supervisor.

Fraud, Waste and Abuse: False Claims Act

Health care fraud, waste and abuse cost taxpayers billions of dollars each year.

Fraud: Intentional deception or misrepresentation to get an unauthorized benefit. The attempt itself is fraud, regardless of whether or not it is successful. It includes but is not limited to making intentional false statements, misrepresentations or deliberate omission of material facts from any record, bill, claim or any other form for the purpose of obtaining payment, services, or any type of compensation for health care services for which you are not entitled.

Waste: Over utilization of services, that result in unnecessary costs.

Abuse: Acting with negligence or a practice inconsistent with sound fiscal, business or medical practices resulting in unnecessary costs to the Medi-Cal program.

Regulations for False Claims Act

Federal FCA (False Claims Act) (Title 31 USC 3279-3733) – Civil penalties between $5,500 to $11,000 per false claim and liability for up to 3 times the damages or loss to the government.

CA FCA (False Claims Act) *(CFCA)* (12650-57 CA Govt. Code) – civil penalties up to $10,000, assessment up to 3x value of the false claim.

These regulations apply to fraud in federal and state health care programs like Medicare and Med-Cal.

Examples: Improper billing such as upcoding (billing using a procedure code for a more expensive service than what was actually performed), unbundling (billing multiple procedure codes which should be covered by a single comprehensive procedure code), billing for services not provided and or/false claims.

Key Points of the Regulations:

- Providers (physicians/hospitals/others) must bill only for services that are provided and documented in the medical record.
- Providers must not try to bill for more services than were provided and documented.
- Providers must use the best billing code available for the service as documented.
- Providers must not add false information to obtain a higher payment.
- Providers must not bill separately for services that should be a single service payment.
- There are substantial financial penalties for violating these regulations (up to three times the amount of the "false claim" plus up to $10,000 per claim). There may also be criminal penalties.
- The FCA protects those who report misconduct under the "qui tam" provision. "Qui tam" is also known as the whistleblower protection provision.
- Whistleblowers are protected under law and may receive a financial reward if the matters they report are substantiated and result in a monetary recovery.

You and Your Staff Role:

- If you think there may have been an error made (such as a billing error) you should report it to the Practice Manager, so that it can be promptly corrected.
- If you think staff or any provider is not following the laws, you should report it. CFMG encourages you to report any suspected inappropriate activity.
- The report must be made "in good faith" meaning that based on what you have seen, you really think there is fraud or abuse of the health care system.

How to report:

- Start with your immediate or office manager. If not satisfied, go to the next step.
- Report to your department director. If not satisfied, go to the next step.
- Report to the Compliance Officer in your practice.
- If you prefer to report anonymously, call your practice's **Compliance Hotline or Officer.**

Please report any incidents as we want you to report so we can work on fixing problems. We cannot fix what we do not know about.

Note: Each office must have a policy of non-retaliation against anyone who reports.

Additional Resources

Anthem Blue Cross

Fraud, Waste and Abuse Hotline: **(888) 231-5044**

Alameda Alliance for Health

Compliance Hotline: **(844) 587-0810**

State and Federal

For Medi-Cal: Department of Health Care Services Medi-Cal Fraud Reporting Line at **(800) 822-6222** or email: **fraud@dhcs.ca.gov**.

HIPAA Overview

Health Insurance Portability and Accountability Act (HIPAA)

Enacted August 21, 1996, these laws protect privacy and security of an individual's health information and prevent the inappropriate use and disclosure of **Protected Health Information (PHI)**. HIPAA requires that health care entities take specific steps to ensure that Member protected health care information (PHI) is not viewed by anyone without "a business need to know," is not stolen, lost or accidentally destroyed.

Protected Health Information is individually identifiable health information in any form or media, whether electronic, paper or oral.

Examples of PHI Identifiers: Name, address, dates, telephone numbers, emails, driver's license number, social security number, medical record number, member ID, etc.

Examples of unsecure PHI: Leaving unattended PHI in open or on one's desk, leaving unattended PHI on the fax machine, copier or printer, writing unencrypted emails with PHI in the body of the email or an attachment.

Reduce the potential of member PHI security breach: Providers can send encrypted emails to CFMG including attachments. Protected health information must be protected in your office. Security for hard copy records and files must adhere to stringent confidentiality standards that meet or exceed the HIPAA regulations and California statutes related to information security.

Reporting Violations

Alameda Alliance for Health: (844) 587-0810 or compliance@alamedaalliance.org

Anthem Blue Cross: (888) 231-5044

Medi-Cal: (800) 822-6222 or stopmedicalfraud@dhcs.ca.gov

California Department of Health Care Services: (800) 822-6222 or fraud@dhcs.ca.gov

CFMG Compliance Documents

Annual Compliance Training
Code of Conduct

Quick Reference Guide for Managed Medi-Cal

Alameda Alliance for Health

Alameda Alliance for Health Member Services . . . . . (510) 747-4567

Alameda Alliance for Health Member Services TTY . . . . . (800) 735-2929

Alameda Alliance for Health Eligibility (Automated Eligibility – Option 2) . . . . . (510) 747-4510

Eligibility (Online). . . . . alamedaalliance.org

Interpreter Services by Phone. . . . . (510) 809-3986
(CFMG PIN: 1002)

Interpreter Services Face-to-Face . . . . . FAX Interpreter Services Request Form to: (855) 891-9167

Anthem Blue Cross

Anthem Blue Cross Customer Care Center . . . . . (800) 407-4627

Anthem Blue Cross Customer Care Center TTY. . . . . .(888) 757-6034

Eligibility (Online). . . . . www.availity.com

Eligibility (Voice). . . . . (800) 407-4627

Automated Eligibility Voice System (AEVS) . . . . . (800) 456-2387

Interpreter Services Face-to-Face. . . . . (800) 407-4627
ssp.interpret@wellpoint.com

Additional Resources

California Children Services Website (CCS) Website . . . . . www.dhcs.ca.gov/services/ccs

CCS Alameda County Office. . . . . (510) 208-5970

CCS Contra Costa County Office . . . . . (925) 313-6400

Child Health and Disability Prevention Program (CHDP) Website . .www.dhcs.ca.gov/services/chdp

CHDP Alameda County Office . . . . . (510) 618-2070
1000 San Leandro Boulevard, Suite 200
San Leandro, CA 94577-1674

CHDP City of Berkeley. . . . . (510) 981-5300
1947 Center Street, 2nd Floor
Berkeley, CA 94704

CHDP Contra Costa County office . . . . . (925) 313-6150
2500 Bates Avenue, Suite B
Concord, CA 94520

Regional Center of the East Bay (developmental disabilities)
Alameda County . . . . . (510) 618-6100
Creekside Plaza
Davis Street, Suite 100
San Leandro, CA 94577

Regional Center of the East Bay (developmental disabilities)
Contra Costa County. . . . . (925) 691-2300
1320 Willow Pass Road, Suite 300
Concord, CA 94530

Important Websites

Children First Medical Group, Inc. . . . . www.childrenfirstmedicalgroup.org

UCSF Benioff Children's Hospital Oakland . . . . . www.childrenshospitaloakland.org

Alameda Alliance for Health . . . . . alamedaalliance.org

Anthem Blue Cross . . . . . www.providers.anthem.com

Centers for Medicare & Medicaid Services . . . . . www.cms.hhs.gov

Medi-Cal . . . . . www.medi-cal.ca.gov

Department of Health Services. . . . . www.dhcs.ca.gov

Department of Managed Healthcare . . . . . www.hmohelp.ca.gov

CFMG Primary Care Physician Scope of Services

Primary Care services reimbursement rates are a capitated fee schedule including but are not limited to the following services: new and established patient office visits, minor surgical procedures performed in the primary care office, and basic laboratory procedures performed in office. Claims that are outside of the PCP capitated service category shall be reimbursed on a fee-for-service basis at current Medi-Cal rates. Directly following this page is a sample list of CPT Codes that are paid on a capitation basis.

Should significant reimbursement and/or billing changes occur throughout the calendar year, CFMG's Provider Relations Department will issue a Provider Newsletter (or News Flash) which will serve to clarify and address any changes in reimbursement or billing methods that may affect your practice and your CFMG members.

CFMG encourages and promotes free and open communication between its network physicians and members/patients regarding all treatment options available regardless of benefit limitations. We believe the doctor-patient relationship is very important and should always be preserved.

Capitated Primary Care Physician Services

Office Visits New Patients	
Procedure Code	**Description**
99201	Office/outpatient visit, problem focused history
99202	Office/outpatient visit, expanded problem focused history
99203	Office/outpatient visit, detailed history
99204	Office/outpatient visit, comprehensive history
99205	Office/outpatient visit, complex history

Office Visits Established Patients	
Procedure Code	**Description**
99211	Office/outpatient visit, minimal problem focused history
99212	Office/outpatient visit, problem focused history
99213	Office/outpatient visit, expanded problem focused history, low complexity
99214	Office/outpatient visit, expanded problem focused history, moderate complexity
99215	Office/outpatient visit, comprehensive problem focused history, high complexity

Minor Surgical Procedures-Integumentary Systems	
Procedure Code	**Description**
10040	Acne surgery
10060	Incision and drainage of abscess
10080	Incision and drainage of pilonidal cyst: simple
10120	Incision and removal of foreign body, subcutaneous tissues: simple
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane
11101	Biopsy, each separate/additional lesion
11200	Removal of skin tags, multiple fibrocutaneous tags, any area
11201	Each additional ten lesions
11400	Excision, benign lesion, except skin tag, trunk, arms or legs: lesion diameter 0.5 cm or less
11401	Lesion diameter 0.6 to 1.0 cm
11402	Lesion diameter 1.1 to 2.0 cm
11420	Excision, benign lesion, except skin tag, scalp, neck, hands, feet, genitalia: lesion diameter 0.5 cm or less
11421	Lesion diameter 0.6 to 1.0 cm
11422	Lesion diameter 1.1 to 2.0 cm
11740	Evacuation of subungual hematoma
12001	Simple repair of superficial wounds 2.5 cm or less
12020	Treatment of superficial wound dehiscence; simple closure
12021	Treatment of superficial wound dehiscence with packing
16000	Initial treatment, first degree burn
16020	Without anesthesia, office or hospital, small

Minor Surgical Procedures-Destruction, Benign Or Premalignant Lesions	
Procedure Code	**Description**
17000	Destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions
17102	Over two lesions, each additional lesion up to 15 lesions
17110	Destruction by any method of flat warts or molluscum contagiosum, milia, up to 15 lesions
17200	Electrosurgical destruction of multiple fibrocutaneous tags, up to 15 lesions
19000	Puncture aspiration of cyst of breast
19001	Puncture aspiration of cyst, each additional cyst
26720	Treat of finger fracture, each
26750	Closed treatment of distal phalangeal fracture
28490	Treatment of closed fracture great toe, phalanx or phalanges
28510	Treatment of closed fracture, phalanx or phalanges, other than great toe
46600	Diagnostic Anoscopy
53670	Insert urinary catheter
69200	Clear outer ear canal
69210	Removal of impacted ear wax

Laboratory Services Urinalysis	
Procedure Code	**Description**
81000	Urinalysis with microscopy
81002	Urinalysis without microscopy
81007	Urine screen for bacteria

Laboratory Services Chemistry And Toxicology	
Procedure Code	**Description**
82270	Test feces for blood

Laboratory Services Hematology	
Procedure Code	**Description**
85014	Hematocrit
85018	Hemoglobin, calorimetric

Laboratory Services Miscellaneous	
Procedure Code	**Description**
82270	Occult blood test
82948	Blood glucose test, reagent strip
84703	Pregnancy test
94160	Basic pulmonary function tests including timed vital capacity and peak flow studies

Collection And Handling Of Blood Or Specimen	
Procedure Code	**Description**
Z5218	Collection/Handling of blood/specimen
Z5220	Collection/Handling of blood/specimen – Other physician services

CFMG Contracting Plans and Products

CFMG and its network physicians have established contractual relationships with the following types of payors: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and other Medical Group/IPAs. To participate in CFMG's PPO Agreements, a physician may elect to participate with these plans by signing and returning a PPO Participation and/or Selection Form sent to your office. If you have Contracting questions, please contact us at **(510) 428-3443**.

If you would like to know which contracts your office/physician participates in, please contact Customer Service at **(510) 428-3154**.

CFMG Customer Service Assistance

Customer Service is available from 8:00 a.m. to 5:00 p.m. Monday through Friday. You can obtain information regarding claims, benefits and eligibility and provider services.

Customer Service provides information and support to all providers about:

- Eligibility of members assigned to PCPs
- Claims questions
- Office address changes
- Contract issues
- Provider Newsletters
- Information on Authorizations and Referrals
- Trainings
- Website Access

When calling about claims to our Customer Service **(510) 428-3154**, please provide the following:

- Member identification number for Anthem Blue Cross or Alameda Alliance for Health
- Member's date of birth
- The date of service and the total billed amount
- Your name, where you are calling from and your telephone number

If it is necessary for you to leave a voicemail, you will receive a call back within 1 business day.

CFMG Provider Claims Appeal Policy

If a provider disagrees with a payment or denial of a claim processed by the CFMG Claims Department, the provider may submit a **CFMG Claim Appeal Form** to the CFMG Claims Department, Attention Claims Manager at:

Children First Medical Group, Inc.
Attn: Claims Manager
6425 Christie Ave., Ste. 110
Emeryville, CA 94608-2245

A provider has up to three-hundred and sixty-five (365) days from the original date of a claims denial and/or billing dispute to submit a written appeal contesting the denial and/or billing dispute.

A. The Claims Manager or Designated Employee will review the appeal.
   1. The Claims Manager or Designee will acknowledge the appeal in writing and indicate the date the letter was sent.
      a. **Paper provider dispute:** Acknowledgement will be provided within fifteen (15) working days of the date of receipt.
      b. **Electronic provider dispute:** Acknowledgement will be provided within two (2) working days of the date of receipt.
   2. If the review by the Claims Manager or Designee indicates additional information is required in order to process the appeal, then the Claims Manager or Designee will be responsible to:
      a. acknowledge the receipt of the appeal within fifteen (15) working days for paper disputes and two (2) working days for electronic disputes; and
      b. include in the acknowledgement letter a complete list of all of the missing information required; and
      c. advise the provider that the information must be received on or before forty-five (45) working days from the date of CFMG's request.
   3. When a provider resubmits the appeal, the resubmission date shall be deemed to be the date of submission.

B. Resolving the Dispute/Appeal

1. Once a complete and accurate appeal has been received, CFMG shall have 45 working days to resolve the dispute except as follows:
    a. If CFMG requests additional information that is reasonably necessary to make an informed determination.
        i. CFMG will inform the provider that it must receive the additional information within 30 working days from the date of request; and
        ii. CFMG shall have 45 working days from receipt of the additional information to resolve the dispute.
2. The Claims Manager, in consultation with policy and program staff, will determine the resolution and advise the provider of the decision.
3. CFMG's determination regarding the provider dispute, including a statement of the pertinent facts and reasons upon which CFMG is relying shall be sent to the provider in writing on or before the expiration of the 45 working day period.
4. If you have questions about an appeal you have submitted, please call Customer Service at **(510) 428-3154**.

Provider Claims Appeal Form (PDF)

CFMG Credentialing

Physician Credentialing

Credentialing is performed according to National Committee for Quality Assurance (NCQA) guidelines for all physician applicants prior to appointment to the CFMG provider panel. Each provider has a confidential credentials file, which contains credentials and quality assurance information. Quality assurance information is contained in a separate area of the file. Credentials files are re-verified every thirty-six (36) months (See Recredentialing Policy). The provider must agree to report immediately any change in status of the information maintained in the Credentials files. All documents for any applicant or reapplicant must be no more than 180 days old at the time they are considered for participation or reapplication. The following documents will be current and maintained in the Credentials file:

1. Current State Medical License
2. Government-Issued Photo Identification
3. Verification of clinical privileges in good standing from the applicant's primary admitting facility
4. Valid Federal Drug Enforcement Agency (DEA) certification or State Controlled Dangerous Substances (CDS) certification (with a California address)
5. Verification of education and training
6. Verification of Board Certification or candidacy, as applicable

7. Verification of Residency and/or Fellowship training in subspecialty for providers that do not hold Board certification in the subspecialty being practiced. (For example: Board certified in Pediatrics with specialty in Pulmonology – fellowship to be verified if not Board certified in Pulmonology.)
8. Work History
9. Current, adequate malpractice insurance according to the IPA's policy
10. Professional liability claims history
11. Verification of delegation of service agreement/physician oversight protocol with supervisor's name (NPs and PAs)
12. Application for membership including a statement consistent with applicable laws, signed by the applicant regarding any reasons for any inability to perform the essential functions of the position, with or without accommodation, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss or limitations of privileges or disciplinary activity. The statement must include an attestation as to the correctness/completeness of the application.
13. A prospective provider office visit report is required of new PCP offices who participate in CFMG's Managed Medi-Cal plans
14. National Practitioner Data Bank Query report (required for all practitioners)
15. SAM (System for Award Management) reports formerly know as Excluded Parties List System (EPLS) U.S. Government Exclusions
16. Federation of State Medical Boards (FSMB) query or State Board Status checks for validation of license and sanction activity with any state in which the applicant is licensed.
17. Sanction Activity verification by Medicare and Medicaid.
18. Social Security Administration 's Death Master File (SSA) query verifies identity and determine Social Security Number (SSN) status (required for all licensed practitioners).
19. National Plan and Provide Enumeration System (NPPES) query verifies National Practitioner Identification Number (NPI) status (required for all licensed practitioners).

Credentialing Criteria

1. Physician must hold a current, active, and unrestricted license to practice medicine in the State of California.
2. Physician must hold a current government-issued photo ID that contains the physician's name, date of birth, gender, expiration date and a tamper-resistant feature.
3. The physician must have a valid DEA or CDS certificate, if applicable.
4. The physician must be in good standing on the medical staff of UCSF Benioff Children's Hospital Oakland or at another Joint Commission accredited local area hospital.
5. The physician must be board certified or board eligible with a satisfactory work history.
6. The physician must have adequate ($1,000,000/$3,000,000) medical malpractice insurance.

7. All specialists must be on staff at UCSF Benioff Children's Hospital Oakland, or a hospital approved by the Board of Directors..
8. The physician must have an acceptable history of malpractice experience. Acceptable is defined as less than two claims in ten years with no claim over $50,000. Exceptions may be made by the CFMG Board of Directors on a case-by-case basis.
9. All primary care physicians participating in CFMG's managed Medi-Cal plans must satisfactorily pass a site visit and medical record review by a Children First Medical Group managed Medi-Cal plan (Alameda Alliance for Health or Anthem Blue Cross) representative.
10. The physician has satisfactorily responded to all questions/statements on the Application including questions about:
    - Physical and mental health status
    - Impairment due to chemical dependency/substance abuse
    - History of loss of license and/or felony convictions
    - History of loss or limitation of privileges or disciplinary activity, and
    - Malpractice history
11. All physicians will be recredentialed every thirty-six (36) months.
12. The physician must have a satisfactory quality profile review.
13. The physician must not have Medicare or Medicaid sanctions.
14. All Medi-Cal managed care network providers mut enroll in the Department of Health Care Services (DHCS) Medi-Cal Fee-For-Service Program. Verification of enrollment is obtained through the California Health and Human Services' (CHHS) Open Data Portal. If the Medi-Cal managed care network provider is not enrolled in the Medi-Cal Fee-For-Service program, the provider will be referred to the appropriate Medi-Cal Managed Care plan (MCP) for enrollment options.

Recredentialing Policy

All Children First Medical Group (CFMG) practitioners will be recredentialed every thirty-six (36) months. The Recredentialing process includes a review of all aspects of credentialing except previously researched history such as work history which would not have changed nor affect the provider's ability to perform quality care.

1. One hundred and eighty (180) days prior to the end of the three-year appointment period, the provider is mailed an application for recredentialing, which is used to update the credentials file information. The CFMG practitioner will also sign a new credentials Verification Release Form and a Release of Insurance Verification.
2. Information, which is currently in CFMG's credentialing database, is sent to the provider for verification and update. Each provider requesting recredentialing must complete an application for membership that includes a current and signed attestation with the following factors:
    - Reasons for any inability to perform the essential functions of the position, with or without accommodation

- Lack of present illegal drug use
- History of loss or limitation of privileges or disciplinary activity
- Current malpractice insurance coverage
- Correctness and completeness of the application

3. Our credentialing staff request that the physician complete a recredentialing application and submit current copies of the following:
   - Copy of state medical license
   - Copy of Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate
   - Copy of face sheet of malpractice coverage
   - Copy of board certification (if certified or changed from original submission)
   - Copy of Clinical Laboratory Improvement Amendments (CLIA) certification or waiver
4. Upon receipt of the completed recredentialing application, verification will be made with the following agencies:
   - Medical Board of California
   - National Practitioner Data Bank
   - Malpractice Insurance Carrier
   - Federation of State Medical Boards (FSMB) or Department of Health and Human Services (DHHS) reports regarding sanction activity by Medicare and Medicaid
5. Verification of clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility.
6. The recredentialing process includes a review of member complaints, results of any quality of care and utilization management surveys or statistics and member satisfaction surveys.

   A site visit and medical record review will be required for all primary care physicians who participate in CFMG's managed Medi-Cal plans.
7. CFMG will conduct site visits for all primary care physicians, and any high-volume specialists designated by the CFMG Board of Directors for complaints related to:
   - Physical Accessibility (e.g., handicapped accessibility)
   - Physical Appearance (e.g., cleanliness and orderliness, well-lit waiting room, posted office hours)
   - Adequacy of Waiting and Examining Room space (e.g., adequate waiting room space, adequate number of examining rooms per practitioner)
   - Adequacy of Equipment (Applicable to CMS only) (e.g., current fire extinguisher, refrigerator housing, specimens and medications is correct temperature and separate from food and personal items, sterilization equipment, current certifications for imaging equipment)
8. Malpractice patterns/trends will be reviewed.

9. Between the recredentialing periods, any licensure investigation will be reviewed. The CFMG Medical Director will review Federation of State Medical Boards (FSMB) or Department of Health and Human Services (DHHS) reports regarding sanction activity by Medicare and Medicaid on a monthly basis.
10. The Credentialing Committee will review the recredentialing materials and recommend physicians for consideration to the Board of Directors, on a monthly basis.
11. The physician will notify the medical group within 30 days of any malpractice or disciplinary action filed against him/her.

Provider Address and Data Changes

The National Committee for Quality Assurance (NCQA) requires that organizations ensure physician information (i.e., provider address, phone numbers, specialty, and board certification) is current, accurate, and communicated to Managed Care Organizations in a timely manner.

To assist Children First Medical Group with maintaining updated directories and other records, please notify Credentialing at **(510) 428-3527** or Customer Service at **(510) 428-3154** if you make a change to your practice. All changes are to be submitted in writing. The Change Documentation table shows some common examples of data changes and the corresponding document that we must receive before the change can be made.

Changes can be submitted in writing to:

Children First Medical Group, Inc.
6425 Christie Ave., Ste. 110
Emeryville, CA 94608-2245
Attn: Provider Updates
FAX: (510) 450-5668

OR by email to: Provider Relations Department at CFMGproviderrelations@ucsf.edu

Change Documentation

Type of Change	Reporting Document
Adding a new practice location	Practice letterhead
Billing Address	Practice letterhead with physician's signature
Changing Tax ID number	Letterhead with copy of W-9
Closing of practice or retiring	Practice letterhead with physician's signature
Addition of a new provider to a practice	Request on Practice letterhead – CFMG will send your office a California Participating Physician Application Packet
New Medical License	Send a copy of the new Medical License
New Drug Enforcement Agency License	Send a copy of the new DEA license
New Malpractice Certification	Send a copy of the new Malpractice Certification
New CLIA Certification or Waiver	Send a copy of the new CLIA Certificate or Waiver

CFMG Physician Disciplinary Policy

A physician may be disciplined by CFMG for a variety of reasons relating both to violations of the CFMG Provider Agreement, including breaches of the CFMG Provider Agreement and Program policies and rules and regulations, and to quality-of-care issues. The applicable disciplinary process and sanctions will depend on the nature of the violation or issue. The term "physician" as used in this Article 2 of these Rules and Regulations includes any licensed or certified health care professionals who participate in CFMG.

1. **Administrative Infractions**

   1.1 **Definition.** Administrative Infractions are violations of CFMG or Program administrative policies. Examples of Administrative Infractions are as follows:

   a. Failure to cooperate with Utilization Review (U.R.) or quality assurance (Q. A.) process, e.g., failure to return phone calls, failure to accept certified letters, failure to discuss cases, discourteousness to (U.R.) or (Q.A.) personnel.

   b. Delay in submission of claims.

   c. Delay in submission of reports.

   d. Failure to comply with Program Enrollee accessibility requirements.

   e. Failure to carry out committee responsibilities.

   f. Failure to return required credentialing documents and data as requested by CFMG.

   The foregoing list of Administrative Infractions is intended to be descriptive, rather than exhaustive.

   1.2 **Procedure.** Administrative Infractions may be identified by the Medical Director, or members of the medical review or claims staff. Each Administrative Infraction will be described in writing on a form specifying the name of the physician, the patient, the date of the infraction, a description of the infraction and the name of the person submitting the form. Notices of Administrative Infractions are provided to the Medical Director for disposition.

   1.3 **Disposition**

   a. The Medical Director or his/her designee will review all notices of Administrative Infractions and notify the physician in writing or by telephone of the receipt of the notice and the steps necessary to correct the physician's practices to avoid future infractions.

   b. All notices of administrative infractions will be maintained in a confidential database and in the physician's file.

   c. The Medical Director, in his/her discretion, can determine that there exists a pattern of Administrative Infractions that when cumulated together reflect a physician's willful disregard of CFMG or Program policies and procedures. Such a determination may be considered a "Third Program Violation" by the Medical Director under the Administrative Sanction Procedure described in Section 3.3 **(Third Program Violation)** below, and the Medical Director may impose or recommend any Administrative Sanction that is commensurate with the pattern of infractions.

2. **Program Violations**

2.1 **Definition.** Program Violations are breaches of the CFMG Provider Agreement and of CFMG and Program policies and procedures relating to utilization of providers and services. Examples of Program Violations by a physician or his/her call coverage physician are as follows:

a. Non-emergency referrals to non-contracting outpatient providers, such as radiology facilities and reference laboratories.

b. Non-emergency referrals to non-participating physicians (except for call coverage where CFMG has been notified of the name, address and telephone number of the call coverage physician).

c. Non-emergency admissions to participating or non-participating hospitals, without prior authorization.

d. Other unauthorized non-emergency out of plan referrals.

e. Inappropriate length of stay or admissions.

f. Surcharging Enrollees.

The foregoing list of Program Violations is intended to be descriptive rather than exhaustive.

2.2 **Procedure.** Program Violations are identified by the Medical Director, or by members of the medical review or claims staff, who shall notify the Medical Director in writing of the occurrence of a Program Violation, using a form specified by CFMG. Upon receipt of notice of a Program Violation, the Medical Director shall invoke the Administrative Sanction Procedure described in Section 3 **(Administrative Sanctions Procedure)**.

3. **Administrative Sanction Procedure**

3.1 **First Program Violation.** Upon determining that a physician has committed a Program Violation for the first time (a "First Program Violation"), the Medical Director or designee shall initiate a warning letter to the physician by certified mail which shall describe the disciplinary process relating to Program Violations. Copies of the letter will be placed in the physician's file and forwarded to responsible CFMG personnel, who will contact the physician for follow up educational purposes. The Medical Director, or their designee, in his/her reasonable discretion, may determine that the seriousness of any First Program Violation, including but not limited to a consistent pattern of over utilization, warrants a recommendation to CFMG Medical Management Committee (MMC) that the Program Violation be treated as a Second Program Violation or a Third Program Violation, as those terms are defined below. The Medical Director or designee shall notify the Physician in writing of his/her notice to MMC with such a recommendation. In such event, the MMC may institute the procedures described in Section 3.2 **(Second Program Violation)**, or 3.3 **(Third Program Violation)**.

3.2 **Second Program Violation.** Upon the occurrence of a "Second Program Violation" within twelve months of the First Program Violation, the Medical Director shall initiate a second warning letter to the physician by certified mail which shall describe the disciplinary process relating to Program Violations. Copies of the letter will be placed in the physician's

file and forwarded to the responsible CFMG personnel, who will contact the physician for follow up educational purposes. The Medical Director, in his/her reasonable discretion, may determine that the seriousness of any Second Program Violation, including but not limited to a consistent pattern of over utilization, warrants a recommendation to the MMC that the Program Violation be treated as a Third Program Violation. The Medical Director or designee shall notify the Physician in writing of his/her notice to MMC with such a recommendation. In such event, the MMC may institute the procedures described in Section 3.3 **(Third Program Violation)**.

3.3 **Third Program Violation**

a. Upon the occurrence of a Third Program Violation within twelve months of the Second Program Violation, the Medical Director or designee, in his/her reasonable discretion may impose any Administrative Sanction described in Section 3.4 (a) – (c), or may recommend to the MMC the imposition of any Administrative Sanction described in Section 3.6 **(Administrative Sanctions)** (d)–(f) or may choose not to impose or recommend a sanction. The imposition of an Administrative Sanction, if any, shall be communicated to the physician in a letter sent by certified mail.

   Copies of the letter will be placed in the physician's file, to the MMC if an Administrative Sanction is imposed, and forwarded to the responsible CFMG personnel, who will contact the physician for follow up educational purposes. The Chief Medical Officer or designee, in his/her reasonable discretion, may determine that the seriousness of any Third Program Violation is cause for a recommendation to CFMG's Board of Directors or its authorized designee that the physician's participation in CFMG be terminated. The Medical Director or designee shall notify the Physician in writing of his/her notice to MMC with such a recommendation. Copies of the letter will be sent to the physician's file, the MMC and the responsible CFMG personnel.

b. Upon receipt of the written notice of a recommendation for termination, the physician, in a letter delivered to the Medical Director or designee within 15 days after the date of CFMG's notice of recommended termination, may request reconsideration of the recommendation. The request must include a statement of the reasons the physician believes the recommendation should be reconsidered. Upon presentation of such a request, the physician will be given an opportunity to attend an informal meeting with the Medical Director or designee and an appropriate committee of the CFMG Board of Directors regarding the circumstances of the recommendation for termination to be convened no later than thirty (30) days after the request.

c. The committee of the CFMG Board of Directors may accept or reject the proposed termination or impose any Administrative Sanction or request additional information prior to making a decision. The decision of the committee of the Board of Directors to terminate a physician, following any such informal meeting with such committee, shall be final. The physician shall have no other procedural rights or hearing rights in connection with such decision and the physician expressly waives any and all other rights to reconsider or challenge any actions relating to the decision. The physician shall be entitled to have his/her written statement placed in his credentials file and

such statement shall be furnished to any physician credentialing body thereafter requesting confirmation of physician's status with respect to the Medical Group.

d. In the event the physician fails to request in a timely manner reconsideration of the recommendation, the Board of Directors or an appropriate committee of the Board of Directors shall determine whether to accept or reject the proposed termination, impose any Administrative Sanction or request additional information prior to making a decision. The physician shall have no procedural rights or hearing rights in connection with the decision of the Board of Directors or any such committee and the physician expressly waives any and all other rights not expressly stated in this Section to reconsider or challenge any actions relating to the decision.

3.4 **Administrative Sanctions.** Administrative Sanctions that may be imposed by the Medical Director or designee, in his/her sole discretion, include those sanctions set forth in paragraphs (a) – (c) below, and sanctions of similar consequence. Administrative Sanctions that may be recommended by the Medical Director or designee and imposed by the MMC include those sanctions set forth in paragraphs (d) – (e) below, and sanctions of similar consequence. As a result of a quality-of-care investigation, the Quality Assurance Committee ("QAC") may impose any of the following Administrative Sanctions or any sanction of similar consequence:

a. Denying payment for the course of treatment at issue unless previously authorized by the applicable Payor in accordance with the provisions of the applicable Payor Agreement.

b. Close scrutiny of the physician's activities by the MMC or another appropriate committee.

c. Requiring that all referrals by the physician be authorized by the Medical Director, except in cases of emergency.

d. Withholding of new Program patients and/or referrals for a specified period of time but allowing the physician to continue treatment of current Program members.

e. Excluding the physician from sharing in any incentives available to CFMG participating physicians.

f. Terminating or suspending the physician's participation in CFMG.

Administrative Sanctions imposed by the Medical Director or designee or the MMC are not subject to any appeal or hearing rights. Only the Administrative Sanctions described in paragraphs (b), (c), (d) and (e) may be considered adverse actions subject to the hearing rights set forth in Section 5, and then only if such Administrative Sanctions are imposed as a result of a quality of care investigation by the QAC, are imposed for a medical disciplinary cause or reason, and constitute significant restrictions on CFMG participation for a cumulative total of 30 days or more in any 12 month period.

3.5 **Confidentiality.** CFMG shall keep all information related to Program Violation matters confidential and shall use such information only for its own purposes, except as required by applicable law.

3.6 **Physician Responses.** Copies of all documents submitted by the Medical Director or designee, the MMC or the QAC for inclusion in CFMG's records related to Program

Violations by physician shall be furnished to physician who shall be afforded an opportunity to submit a written response to be maintained in CFMG's records.

4. **Quality of Care Actions**

4.1 **Definition.** Quality of care actions relate to the conduct, performance or competence of physicians and are intended to address conduct that requires the filing of an "805 report" with the Medical Board of California or other appropriate State licensing board. A quality of care action may be initiated when the Medical Director receives information that a physician's conduct may be detrimental to patient safety, unethical or below applicable professional standards.

4.2 **Procedure**

a. Quality of care actions that are initiated by the Medical Director or designee will be referred to the QAC. The request must be supported by reference to specific activities or conduct alleged.

b. The members of the QAC shall consider the quality assurance action and may conduct an investigation or shall assign the task to an appropriate delegate. The physician shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the QAC shall reasonably establish. The QAC may, but is not obligated to, conduct interviews with persons involved. The investigation shall not constitute a "hearing" as that term is used in Section 5 **(Hearing Rights)** below, nor shall the procedural rules with respect to hearings apply.

c. As soon as practicable after the conclusion of the investigation, the QAC shall deliver to the Medical Director a report which shall include findings and recommendations. The recommendations may include, without limitation:

i. No formal corrective action. This is appropriate when the QAC finds either that the allegations are without merit or that the alleged conduct lacks sufficient seriousness to warrant further corrective action.

ii. Deferring action for a reasonable time, where circumstances warrant.

iii. Issuing letters of admonition, censure, reprimand or warning.

iv. Recommending any Administrative Sanction, as described in Section 2.3.6 **(Administrative Sanctions)** above.

v. Recommending termination of participation in CFMG.

4.3 **Disposition.** The Board of Directors shall review the recommendations of the QAC and take such action as it deems appropriate, subject to any right the physician may have to request a hearing under the procedures described in Section 5 **(Hearing Rights)** or Section 4.5 **(Fifth Program Violation)** as applicable.

4.4 **Summary Suspension**

a. Whenever a physician's conduct appears to require that immediate action be taken to protect the life or wellbeing of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health or safety of any patient or other person, the Chief Medical Officer may summarily restrict or suspend such

physician's participation in CFMG. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the Chief Medical Officer shall promptly give written notice of the action to the physician, the Board of Directors of CFMG and the QAC. The summary restriction or suspension shall remain in effect for the periods stated in the notice, or if none is stated, until resolved as set forth herein. Unless otherwise indicated by the notice of summary restriction or suspension, the physician's patients shall be promptly assigned to another physician by the Member's health plan.

b. Not later than three (3) business days after a summary restriction or suspension has been imposed, a meeting of the QAC shall be convened to review and consider the action. Upon request, the physician may attend and make a statement concerning the issues under investigation, in accordance with such procedures as the QAC may reasonably impose, although in no event shall any meeting of the QAC, with or without the physician, constitute a "hearing" within the meaning of Section 5 **(Hearing Rights)**, below, nor shall any procedural rules apply, except as determined by the QAC. The QAC may modify, continue or terminate the summary restriction or suspension, but in any event it shall furnish the physician with notice of its decision.

c. Unless the QAC terminates the summary restriction or suspension within five (5) business days after it is imposed, the physician shall be entitled to the procedural rights afforded by Section 5 **(Hearing Rights)** or Section 3.5 **(Fifth Program Violation)** as applicable.

4.5 **Automatic Suspension or Limitation.** In the following instances, the physician's participation in CFMG may be suspended or limited as described, in which action shall be final without a right to hearing or further review, except where a bona fide dispute exists as to whether the circumstances have occurred, as determined by CFMG Board of Directors.

a. Whenever a physician's license or other legal credential authorizing practice in this State is revoked, suspended, limited or restricted, CFMG participation shall be automatically revoked, suspended, limited or restricted in a similar manner, as of the date such action becomes effective.

b. Whenever a physician is placed on probation by the applicable licensing or certifying authority, his/her CFMG participation status shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

Nothing in this Section 4.5 shall preclude the imposition of sanctions, other than those automatically imposed, pursuant to the provisions of these Rules and Regulations.

4.6 **Limitation on Rights Afforded Certain Practitioners.** If the QAC recommends termination of a person's participation in CFMG and such person is other than a physician and surgeon, podiatrist, clinical psychologist or dentist, the recommendation shall be treated as a Fifth Program Violation under Section 3.5 **(Fifth Program Violation)** giving rise to the right to request reconsideration of the recommendation, as set forth therein. Such person shall not be granted the rights afforded by Section 5 **(Hearing Rights)**.

5. **Hearing Rights**

5.1 **General Provisions**

a. **Exhaustion of Remedies.** If adverse action described by Section 5.2 **(Grounds for Hearing)** is taken or recommended, the physician shall have the rights, and before resorting to legal action must exhaust the remedies, afforded by these Rules and Regulations.

b. **Meanings of Terms.** For purposes of this Section 5, the term "physician" may include an applicant for participation in CFMG, as it may be applicable under the circumstances.

5.2 **Grounds for Hearing.** Except as otherwise specified in these Rules and Regulations, any one or more of the following actions shall be deemed final proposed adverse actions and constitute grounds for a hearing:

a. A physician's application for participation in CFMG is denied or rejected for a medical disciplinary cause or reason.

b. A physician's participation in CFMG is terminated or revoked for a medical disciplinary cause or reason.

c. Significant restrictions are imposed or voluntarily accepted on CFMG participation for a cumulative total of 30 days or more in any 12-month period, for a medical disciplinary cause or reason.

For purposes of these Rules and Regulations, a medical disciplinary cause or reason means that aspect of a physician's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

5.3 **Request for Hearing**

a. **Notice of Final Proposed Adverse Action.** In all cases in which a final proposed adverse action has been taken as set forth in Section 5.2 **(Grounds for Hearing)**, the QAC shall give the physician prompt written notice (i) of the final proposed adverse action, (ii) that such action, if adopted, shall be taken and reported to the Medical Board of California or other appropriate State licensing board pursuant to Section 805 of the California Business and Professions Code, (iii) of the right to request a hearing pursuant to Section 5.3(b) Request for Hearing), and (iv) that such hearing must be requested within 30 days after receipt of the notice.

b. **Request for Hearing.** The physician's request for a hearing shall be in writing addressed to the QAC with a copy to the Board of Directors of CFMG. In the event the physician does not request a hearing within the time and in the manner described, the physician shall be deemed to have waived any right to a hearing and accepted the action involved.

c. **Time and Place for Hearing.** Upon receipt of a request for hearing, the QAC shall schedule a hearing in accordance with the following procedure:

i. The date of the hearing shall be not less than 15 nor more than 60 days after receipt by the QAC of the request for a hearing, unless the Judicial Committee issues a written decision delaying the hearing as a result of the physician's failure

timely to provide access to information as required by these Rules and Regulations; provided that if the physician is under summary suspension, the hearing shall be held as soon as arrangements may reasonably be made, but in no event more than 20 days after receipt by the QAC of the request for a hearing.

ii. Notice of the date, time and place of the hearing shall be given to the physician not less than ten (10) days, or more than fifteen (15) days prior to the date of the hearing.

d. **Notice of Charges.** Together with the notice stating the date, time and place of the hearing, the QAC shall state clearly and concisely in writing the reasons for the final proposed adverse action, including the acts or omissions with which the physician is charged.

e. **Judicial Committee.** When a hearing is requested, the CFMG Board of Directors shall appoint a Judicial Committee which shall be composed of not less than five physicians who shall gain no direct financial benefit from the outcome, and who have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the action. Knowledge of the matter involved shall not preclude a physician from serving as a member of the Judicial Committee. Appointment of the Judicial Committee shall include designation of the chairman. Membership on a Judicial Committee shall include, where feasible, an individual practicing the same specialty as the physician.

f. **The Hearing Officer.** CFMG shall appoint a hearing officer to preside at the hearing. The hearing officer shall gain no direct financial benefit from the outcome of the hearing and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant, oral and documentary evidence in an efficient and expeditious manner and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, and the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the Judicial Committee, the hearing officer may participate in its deliberations and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

g. **Failure to Appear or Proceed.** Failure without good cause of the physician requesting the hearing to appear and proceed at such hearing shall be deemed to constitute voluntary acceptance of the recommendation or action involved, which shall become the final action of CFMG.

h. **Postponements and Extensions.** Postponements and extensions of time beyond the times expressly permitted in these Rules and Regulations may be requested by anyone and may be permitted by the hearing officer only on a showing of good cause.

5.4 Hearing Procedure

a. Pre-Hearing Procedure

i. Within fifteen (15) days after a written request by either party to the hearing of a list of witnesses and copies of documents expected to be introduced at the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing, and copies of such documents. Failure to disclose the identity of a witness or produce copies of documents expected to be produced at least 10 days before the commencement of the hearing shall constitute good cause for a continuance.

ii. The physician shall have the right to inspect and copy at his/her expense any documentary information relevant to the charges which CFMG has in its possession or under its control, as soon as practicable after receipt of the physician's request for a hearing. The QAC shall have the right to inspect and copy at its expense any documentary information relevant to the charges which the physician has in his/her possession or control as soon as practicable after receipt of the QAC's request for such inspection.

iii. The failure by either party to provide access to documentary information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians, other than the physician under review.

iv. The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice require. When ruling upon a request for access to information and determining the relevancy thereof, the hearing officer shall consider, among other factors, the following:

- Whether the information sought may be introduced to support or defend the charges.
- The exculpatory or inculpatory nature of the information sought, if any.
- The burden imposed on the party in possession of the information sought, if access is granted.
- If there has been any previous request for access to information submitted or resisted by the parties to the same proceeding.

v. The physician shall be entitled to a reasonable opportunity to question and challenge the impartiality of the Judicial Committee members and the hearing officer. Challenges to the impartiality of any Judicial Committee member or the hearing officer shall be ruled on by the hearing officer.

vi. It shall be the duty of the physician and the QAC or its designee to exercise reasonable diligence in notifying the chairman of the Judicial Committee of any pending or anticipated procedural disputes as far in advance of the scheduled

hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

b. **Representation.** All parties shall be entitled to representation by legal counsel at the hearing. CFMG cannot have an attorney, if the practitioner does not have attorney representation [Bus. & Prof. Code 809.3 (C)].

c. **Record of the Hearing.** A shorthand reporter shall be present to make a record of the hearing proceedings. The cost of attendance of the shorthand reporter shall be borne by CFMG, but the cost of the transcript, if any, shall be borne by the party requesting it.

d. **Rights of the Parties.** At the hearing, both sides shall have the following rights: to be present; to call, examine and cross examine witnesses; to present and rebut evidence determined by the hearing officer to be relevant; to submit a written statement at the close of the hearing. If the person who requested the hearing does not testify on his/her own behalf, he/she may be called and examined as if under cross examination.

e. **Miscellaneous Rules.** Judicial rules of evidence and procedure relating to conduct of the hearing, examination of witnesses and presentation of evidence shall not apply to a hearing conducted under this provision. All relevant evidence which responsible persons are accustomed to relying on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law, shall be admitted by the hearing officer. The Judicial Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Committee may request both sides to file written arguments.

f. **Burden of Presenting Evidence and Proof**

   i. At the hearing, the QAC shall have the initial duty to present evidence in support of its action or recommendation.

   ii. An initial applicant for participation in CFMG shall bear the burden of persuading the Judicial Committee by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership. An initial applicant shall not be permitted to introduce information requested by CFMG but not produced during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

   iii. Except as provided above for initial applicants, the QAC shall bear the burden of persuading the Judicial Committee by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

g. **Adjournment and Conclusion**

   After consultation with the chairman of the Judicial Committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the QAC and the physician may submit a written statement at the close of the hearing.

Upon conclusion of the presentation of oral and written evidence, and the receipt of closing written arguments, if submitted, the hearing shall be closed.

h. **Decision of the Judicial Committee**

Within 30 days after final adjournment of the hearing, the Judicial Committee shall render a decision which shall be accompanied by a report in writing. If the physician is currently under suspension, however, the time for the decision or report shall be not more than 15 days after final adjournment. The decision of the Judicial Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

A copy of said decision shall be forwarded to the Chief Medical Officer, the Board of Directors of CFMG, the QAC and the physician, and a copy shall be maintained in the physician's file. The report shall contain a concise statement of the reasons in support of the decision, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The decision of the Judicial Committee shall be considered final and there shall be no rights of appeal.

6. **Termination of Physician Agreement without Cause**

The procedures set forth in this Article 2 shall not apply to the termination of a CFMG Provider Agreement other than for a medical disciplinary cause or reason, except as may be required by applicable law.

7. **Reports to Governmental Entities**

The organization shall make all reports to governmental entities upon the taking of any final action as to any physician required by Section 805/805.01 gt sea. of the California Health and Safety Code and the Federal Health Care Quality Improvement Act or other applicable law.

CFMG Physician Availability

Coverage

As a physician for Children First Medical Group, Inc. you must be able to assure that services are available on a 24 hours a day, 7 days a week basis.

If you are going to be unavailable because of illness, vacation, or an unplanned event you must contact another CFMG contracted physician to cover for you in your absence, the term for this is known as Locum Tenens.

Payments

If you arrange for another contracted physician to cover for you, you should make payment arrangements with that physician for visits that will be considered "capitated."

After-Hours Phone Coverage

Your after-hours phone message must direct families who are involved in a life-threatening emergency to hang up and dial 911. You also must provide a way for the member to reach you or the covering physician, either via cell phone or pager.

Please, notify CFMG Customer Service if you are planning an extended stay away from your office.

If you have any questions about Physician Availability please contact Customer Service at **(510) 428-3154**.

CFMG Access to Care, Standards and After-Hours Services/Timely Access

Access to care standards for Managed Medi-Cal members are set by the following organizations:

- National Committee for Quality Assurance (NCQA)
- Department of Health Care Services (DHCS)
- California Department of Managed Health Care (DMHC)
- Managed Care Plans (Anthem and Alameda Alliance for Health)

Anthem Blue Cross and Alameda Alliance for Health and the Department of Managed Health Care conduct annual surveys to enforce these standards. If CFMG providers fail to meet these standards during the surveys, CFMG may receive a Corrective Action Plan and CFMG will reach out to providers for education and for corrective action plans.

Below is a link from the Department of Managed Health Care:
dmhc.ca.gov/Portals/0/Docs/DO/TAC_accessible.pdf

https://alamedaalliance.org/wp-content/uploads/Provider-Manual_10072021-clean.pdf – Please see pages 22-23 in the Provider Manual

providers.anthem.com/docs/gpp/california-provider/CA_CAID_ProviderManual.pdf
– See pages 7-8

After-Hours Care

Participating physicians are responsible for offering members access to covered services 24 hours a day, 7 days a week. When unavailable, providers must arrange for on-call coverage by another participating provider.

For after-hours calls: The answering service or after-hours personnel must ask if this is an emergency. In the event of an emergency, the member should be immediately directed to dial 911 or go to the nearest hospital or emergency room.

When staff is not available and an answering service is used, the answering machine should instruct the member in event of an emergency, to dial 911 or go the nearest emergency room. The message should also give members an alternative contact number to reach the primary care physician (PCP) or

on-call provider. In addition, non-English speaking members who call their PCP or on-call physician should get language appropriate messages.

In a nonemergency situation, members should receive instructions on reaching the on-call physician.

CFMG Physician Retirement/Termination and Continuity of Care Policy

Voluntary Contract Retirement/Termination

As a CFMG Participating Provider, you are required by your Provider Agreement) to provide CFMG with **ninety (90) calendar days prior written notice**, of your intent to terminate your network participation with the medical group.

In accordance with Section 1373.65(b)-(d) of tement, it is critical that timely notice be given to CFMG and its staff. **Notices not submitted in accordance with our policy will be processed based upon the date of receipt. Therefore, the ninety (90) day "term period" will start from the date that CFMG receives the notice.**

CFMG also reserves the right to terminate a physician's provider agreement without cause and/or for breach.

Address to submit termination notice:

Children First Medical Group, Inc.
Provider Relations Department
6425 Christie Ave., Ste. 110
Emeryville, CA 94608-2245
FAX (510) 450-5668
CFMGproviderrelations@ucsf.edu

Anthem Blue Cross requires the providers notify CFMG/Anthem Blue Cross with a minimum of 120 calendar days for terminations to ensure timely member notifications (see page 78 of the Anthem Blue Cross Manual): **providers.anthem.com/docs/gpp/california-provider/CA_CAID_ProviderManual.pdf**

Continuity of Care Provisions for a Terminating Provider

The completion of covered services shall be provided by a terminated provider to a member who at the time of the contract's termination was receiving services from that provider for one of the conditions described below.

Provider shall provide for the completion of covered services for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice.

   Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.
3. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.
4. The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
5. Performance of a surgery or other procedure that is authorized by CFMG as part of a documented course of treatment and documented by the provider to occur within 180 days of the contract's termination date.

Participation Requirements for a Terminating Provider

CFMG may require that a provider agree in writing to be subject to the same contractual terms and conditions that were imposed upon that practice prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. As the terminating provider if you do not agree or comply with the contractual terms and conditions, CFMG is not required to continue your services beyond the contract termination date.

Reimbursement for a Terminating Provider

Services provided shall be compensated on a rate agreed upon by both CFMG and provider. Neither CFMG nor the provider is required to continue with services if an agreeable rate of reimbursement cannot be decided.

CFMG Medical Management

Child Health and Disability Prevention Program (CHDP)

Preventative Health Program for Infants, Children and Teens

Health and Safety Code, Section 124025, et seq., established the Child Health and Disability Prevention (CHDP) program. When the CHDP program was implemented in 1973, its primary purpose was to implement Federal Medi-Cal Early and Periodic Screening mandates in California.

All managed Medi-Cal recipients from birth to age 21 are eligible for CHDP scheduled periodic health assessments and services.

Every county health department in the State and the health departments in the cities of Berkeley, Long Beach and Pasadena operate a CHDP program.

Children First Medical Group primary care physicians participate in CHDP.

The local CHDP offices provided education for all new providers and audit the medical records every three years.

CFMG providers will continue to bill Children First Medical Group for Child Health and Disability Prevention (CHDP) Early and Periodic Screening, Diagnosis and Treatment health assessments, immunizations and ancillary services on a CMS-1500.

Additional Resources

Alameda County: www.acphd.org/chdp.aspx
Contra Costa: cchealth.org/chdp
CHDP Training and Resource material: www.dhcs.ca.gov/services/chdp/Pages/Training.aspx

Standards: CHDP base basement standards on the American Academy of Pediatrics Bright Futures Recommendations for Periodic Preventative Health Care:
www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx
www.dhcs.ca.gov/services/chdp/Pages/HAG.aspx

Cultural and Linguistic Training

Anthem Blue Cross

For cultural and/or linguistic requests either by member or by providers, please use the following referral form: providers.anthem.com/docs/gpp/california-provider/CA_CAID_HealthEdReferralForm.pdf?v=202010122213

Cultural Sensitivity Training – there is a toolkit, Caring for Diverse Populations: https://providers.anthem.com/docs/gpp/california-provider/CA_CAID_CaringforDiversePopulationToolkit.pdf?v=202010062345

Alameda Alliance for Health

Cultural and Sensitivity Training available at: https://alamedaalliance.org/wp-content/uploads/2020-Cultural-Sensitivity-Training-for-Providers_Condensed_approved_posted-08312020.pdf

Training covers the use of language services, culture's impact on healthcare, working with members with disabilities, LGBT, aging, refugees and immigrants and more.

Interpreter Services

Anthem Blue Cross

During business hours face-to-face interpreters for members needing language including American Sign Language are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required. Over the phone interpreters are available 24 hours a day, 7 days a week. During business hours call, **(800) 407-4627**. For more information, follow this link:

Interpreter Services Desktop Reference Guide: https://providers.anthem.com/docs/gpp/california-provider/CA_CAID_InterpreterServicesDesktopReference.pdf?v=202111221735

After-hours telephone interpreter services, members can call the 24/7 NurseLine at

(800) 224-0336, TTY (800) 368-4424

Alameda Alliance for Health

The Alameda Alliance for Health provides free telephonic and in-person interpreter services, including American Sign Language, for Alliance covered services. Call member services during business hours at **(510) 747-4567 or (877) 932-2738** to arrange for in person interpreter as soon as the need is identified.

Requests should be made at least 5 working days prior to the member's appointment for face-to-face interpretation.

Interpreter Provider Guide: https://alamedaalliance.org/wp-content/uploads/Interperter-Services-Provider-Guide_05102021.pdf

Please complete the Interpreter Request form: www.childrenfirstmedicalgroup.com/downloads/AAH_InterpreterServices_RequestForm_20210325.pdf

TTY (800) 735-2929

Initial Health Assessments (IHA)

Children First Medical Group member primary care physicians should administer the Staying Healthy Assessment (SHA) to all Medi-Cal members as part of the Initial Health Assessment (IHA). The goal of the IHA is to assess acute, chronic and preventative health needs.

CFMG will mail the IHA reports for both plans to your office monthly.

The IHA at a minimum should include:

- A physical and mental health history
- Identification of high-risk behaviors
- Assessment of need for preventive screenings or services and health education
- Diagnosis and plan for treatment of any disease

The IHA should be conducted in a culturally and linguistically appropriate manner for all patients, including those with disabilities. The benefits of the IHA will allow for more personalized care plans and streamlines HEDIS documentation ensuring members get preventative services. The IHA is monitored and scored when the health plans conduct Medical Record Reviews.

Periodicity

CFMG primary care providers should ensure that each member completes the IHA according to the following guidelines and timeframes. If a member refuses to complete the IHA, it should be documented on the appropriate age-specific form and kept in the member's medical record.

If the member is your patient in the past year or more, and there is documentation showing the IHA was completed in the last 12 months, a new IHA is not needed.

New members must complete the IHA within 120 days of the effective date of enrollment.

The medical record should include a Staying Healthy Assessment questionnaire appropriate for their age. www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

Resources

Alameda Alliance for Health: www.alamedaalliance.org

Frequently Asked Questions:
www.dhcs.ca.gov/formsandpubs/forms/Documents/MMCD_SHA/GenDocs/SHA_FAQs.pdf

Policy Letter from DHCS:

www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2013/PL13-001.pdf

Current list of All Staying Healthy Assessments:
www.dhcs.ca.gov/formsandpubs/forms/Documents/MMCD_SHA/GenDocs/SHA_FAQs.pdf

Facility Site Review

In order to promote high quality health care to our members who are your patients, and to meet the National Committee for Quality Assurance (NCQA) and Department of Health Care Services (DHCS) stringent requirements regarding quality assurance, Children First Medical Group is requiring that a detailed office review be completed within a three-year period prior to the Credentialing Committee's review and final confirmation into the CFMG network and, at least, every three years during the recredentialing process.

Physician offices providing care for Medi-Cal Managed Care members will be surveyed by Alameda Alliance for Health or Anthem Blue Cross Quality Management staff. Providers are required to meet the DHCS standards as outlined in the Facility Site Review Tool, Medical Record Review Tool, and the **Physical Accessibility Review Survey**. The Health Plans will provide each office with a copy of the survey tool prior to the scheduled review. In addition, there is a copy of the survey tool in this section.

Facility Site Review Tool: https://www.childrenfirstmedicalgroup.com/ProviderManual/PM_Site_Review_Tool.pdf

Medical Record Review Tool: https://www.childrenfirstmedicalgroup.com/ProviderManual/PM_Medical_Record_Review_Tool.pdf

The following list includes areas that will be addressed during the office review.

Access and Safety

- Wheelchair accessibility
- Disabled Parking
- Elevator or Floor Access
- Waiting Accommodations
- Office Cleanliness
- Emergency Health Care Equipment
- Medical and Lab Equipment

Personnel

- Professional Licenses/Certifications
- Personnel Training and documentation
- Safety Training
- Member Rights Training

Office Management

- Twenty-four-hour physician coverage
- Interpreter Services
- Referral & Authorization Services
- Member Grievance/Complaint Process
- Medical Record Storage

Clinical Services

- Medication Storage System
- Process for Expired Drug Monitoring and Disposal
- Drug Dispensing Process
- CLIA Certification

Preventive Services

- Pediatric Examination Equipment
- Pediatric Screening Equipment
- Vision Screening Equipment
- Audiometric Screening Equipment
- Health Education Materials

Infection Control

- Infection Control Supplies
- Infection Control Procedures
- Staff Training
- Immunization Equipment
- Personal Protective Equipment
- Needlestick Safety
- Medical Waste Disposal
- Biohazardous Waste Disposal
- Equipment Sterilization Procedures

Facility Site Review Tool (PDF)

Medical Record Review

The medical record review is also an integral part of the Credentialing process. Medical records that are maintained in a manner that is current, detailed and organized promote appropriate health management and quality for your patients. Medical records of new CFMG providers will be reviewed within 90 calendar days of the date on which members are first assigned to the provider. Subsequent reviews will be completed, at least, every three years during the recredentialing process.

For physicians providing care for the Medi-cal Managed Care members, the Health Plans will provide each office with a copy of the DHCS Medical Record Review Tool prior to the scheduled review. Health Plan staff will complete a structured review of ten (10) randomly chosen CFMG member medical records per physician. Sites where documentation of patient care by multiple PCPs occurs in the same record shall be reviewed as a "shared" medical record system. Shared medical records shall be considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records shall be reviewed if two to three PCPs share records, 20 records shall be reviewed for four to six PCPs and 30 records shall be reviewed for seven or more PCPs.

The following list includes areas that will be addressed during the DHCS Medical Record Review.

Medical Record Organization

- Health Assessment Information
- History and Physical Examination
- Lab Reports
- Radiology Reports
- Progress Notes
- Consultation Notes
- Immunization Records

Documentation

- Current List of Medications
- Allergies Flagged and Listed
- Appropriate Use of Consultants
- Problems from Previous Visits Addressed
- Plans of Action/Treatment
- Appropriate Documentation of Consultation Follow-up
- Evidence of Continuity and Coordination of Care
- Patient Identification (name, address, birthdate, sex, etc.)

Coordination/Continuity of Care

- History of Present Illness
- Working Diagnoses
- Treatment Plans
- Instructions for Follow-up Care
- Unresolved/Continuing Problems are Addressed
- Consult/Referral Reports are Reviewed
- Missed Appointment Follow-up

Pediatric Preventive Care

- Initial Health Assessment
- Individual Behavioral Assessment
- Age Appropriate Exams
- Vision Screening
- Hearing Screening
- Nutritional Assessment
- Dental Assessment
- Lead Screening
- Tuberculosis Screening
- Childhood Immunizations

The following list includes areas that will be addressed during the PPO Medical Record Review.

- Medical record security and accessibility
- Medical record organization
- Documentation of patient refusal of Interpretation services
- All entries signed with practitioner credentials.

Medical Record Review Tool (PDF)

Primary Care Physician Preventive Health Care Guidelines

The Primary Care Physician is responsible for providing initial and primary care to members, maintaining the continuity of patient care, and initiating referral for specialist care. The following guidelines include those services recommended for routine pediatric health maintenance and preventive care. These represent a minimum level of service and it is expected that physicians will provide care that extends beyond these basic guidelines when necessary.

- **Recommendations for Preventive Pediatric Health Care** published by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics (downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- **Recommended Childhood Immunization Schedules** approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf).

CFMG Referrals and Authorizations

Referrals to Specialist

Direct referrals can be made to CFMG contracting specialists by the Primary Care Physician using the CFMG Specialty Referral Form.

- Primary Care Physician evaluates member to determine the need for specialty referral.
- Primary Care Physician completes the Specialty Referral Form.

  Include pertinent information and number of authorized visits.
- Primary Care Physician faxes the Specialty Referral Form to the Specialist and gives a copy to the patient.
- Member schedules appointment with the Specialist.
- Referral Specialist notifies Primary Care Physician of outcome.
- Referral Specialist attaches a copy of the Specialty Referral Form to the initial claim submitted to CFMG.
- Claim is paid according to the number of visits authorized on the Specialty Referral Form.
- All extension requests must be referred back to the Primary Care Physician.
- Sub-specialty consultations and second opinions must be requested through the Primary Care Physician.

We will be unable to process incomplete and/or illegible requests. Please request with full clinical information and include copy of chart notes.

Specialty Referral Form (PDF)
Instructions for a Specialist Receiving a PCP Referral (PDF)
Process for Specialist Referral Extensions (PDF)

Prior Authorization Process

Primary Care Physician/Specialist

- **Primary Care Physicians:** Following evaluation, Physician submits the authorization request using the **EZ-Net electronic system**, or the Request for Authorization Form.
- **Specialists:** Following evaluation, Physician completes the Request for Authorization Form.
- Check **URGENT BOX** if services are required **within 72 hours**.
- Fax the **Request for Authorization** to CFMG at **(510) 450-5868** to request services.

Please refer to the following page for a list of services which require prior authorization.

- Specify which contracted facility will be used to provide the services.
- CFMG reviews non-urgent requests for approval or denial **within five (5) working days of receipt**.
- CFMG reviews urgent requests for approval or denial **within 72 hours of receipt**.
- CFMG notifies member, PCP, and provider of the authorization or denial.
- Physician schedules services or notifies member to schedule services.
- Provider notifies Primary Care Physician of results.

We will be unable to process incomplete and/or illegible requests. Please complete form with full clinical information and include copy of chart notes.

Request for Authorization Form (PDF)
Services That Require Authorization (PDF)

EZ-NET Authorization Process

Log in to the CFMG website www.childrenfirstmedicalgroup.com under UM

Log in to EZ-NET (link on the upper right corner)

- Enter your user ID
- Enter your password

Authorization Submission

Click "Authorizations – Submission" link in the function menu.

1. Choose company ID – auto populated.
2. **Request Date:** This is auto populated by the system
3. **LOS:** No need to populate.
4. **Units:** No need to populate.
5. You must fill in all fields that have a red asterisk. You can use the magnifying glass for look up.
6. Add **health plan member ID**. You can use binoculars to search for member's ID. Once the ID is entered, the system automatically populates the member's name, sex and date of birth. If you

cannot locate the member, please verify eligibility and call the Children First Medical Group (CFMG) Utilization Management (UM) Department at **(510) 428-3489** for assistance.

7. **Members PCP:** Once you add the member ID number, the member's PCP will automatically pop up.
8. **Performing physician:** If you don't know the physician, just use the magnifying glass to choose the provider. If you cannot locate the provider, call the CFMG UM Department for assistance.
9. **Facility ID:** No need to populate.
10. **Place of service** (it will usually be #11 or #22): Use the drop-down menu for any other place of service.
11. **Diagnosis code:** You must add the diagnosis code. Once you enter it the information regarding that code will show up automatically. Then, YOU MUST PRESS ADD. You can add up to 4 diagnosis codes. Use magnifying glass to search.
12. **Procedure code:** You must add the procedure code, e.g., 99241, etc. You also must enter which diagnosis code you're referring to – e.g., #1 on the diagnosis code list. Also, enter quantity and modifier. Then, YOU MUST PRESS ADD.
13. **Authorization notes:** Fill in the information requested. Please start your notes AFTER THE SCRIPT, so we can easily read the requested information.
    - Please submit your name, phone and fax number.
    - Indicate if the request is urgent, routine, or post-service.
    - Urgent requests will be processed within 72 hours, routine requests within 5 business day, and post-service requests within 30 calendar days.
    - Add relevant clinical information, treatment to date, and reason for the request.
    - Indicate if this is a CCS eligible condition, and if you referred to CCS.
    - For a Healthy Hearts request, we only need the height, weight, BMI and BMI%.
14. Then press **Submit Request** – Please hit it only ONCE. You may have to wait a minute while the system accepts it. Do not hit it more than once, or it will jam the system.
15. You will then get a statement that says, "Request Succeeded," etc. It will give you an authorization request number.
16. **If there is a technical difficulty, do not resend. Please call (510) 428-3154 and leave a message for the CFMG Network Administrator.**
17. **VERY IMPORTANT** – when logging off do not hit the X box in the upper right-hand corner. If you do, it will keep you in the system. Instead, look on the left side of your screen and choose "**Log Off**."
18. After the CFMG UM Department processes the request, you will receive a fax copy of the authorization approval/or denial letter.

Authorization Criteria

Medical decision determinations that involve the nature and level of care a member receives are solely based on the necessity of that care and service and are made by qualified medical providers. Practitioners or other individuals providing care or making utilization review determinations are not rewarded or penalized based upon denials of care. The Medical Group does not provide any financial incentives to encourage decisions that result in under-utilization of care. Practitioners are ensured independence and impartiality in making referral decisions which will not influence hiring, compensation, termination, promotion, or any other similar matters. The physician reviewer may be contacted at **(510) 428-3443** to discuss any UM denial decisions.

The criteria used in the determination of medical appropriateness of services are made available to providers upon request. To obtain a copy of the Utilization Criteria, or Clinical Practice Guidelines as developed, please submit a written request to the CFMG Medical Management Department.

Medical Management Programs

Upon request, CFMG makes information about our Utilization Management Program available to our practitioners and members, including a description of the Program, the policies and procedures, and a report of the organization's progress in meeting our goals.

To obtain a copy of the Utilization Management Program information, please submit a written request to the CFMG Medical Management Department.

In-Office Procedures

Primary Care Physician/Specialist

- **Primary Care Physician** evaluates member need for in-office procedure. If the procedure requires prior authorization, the Physician submits the authorization request using the **EZ-Net electronic system** or the Request for Authorization Form.
- **Specialist** evaluates member need for in-office procedure. If the procedure requires prior authorization, the physician completes the Request for Authorization Form.
- Check **URGENT BOX** at top of Request for Authorization Form if services required **within 72 hours**.
- Fax/mail a copy of the form to CFMG. The copy is retained for the physician's file.
- CFMG reviews non-urgent requests for approval or denial **within five (5) working days of receipt, and urgent requests within 72 hours**.
- CFMG notifies the member and physician(s) of the authorization or denial.

We will be unable to process incomplete and illegible requests. Please complete form with full clinical information and include copy of chart notes.

Hospitalization/Outpatient Surgery

Primary Care Physician/Specialist

Elective Procedures or Admissions:

- **Primary Care Physician** or Specialist completes the Request for Authorization Form.
- The Physician completes Request for Authorization Form with the necessary clinical information, proposed facility, and date of service. Physician may attach consultation report form. Physician faxes a copy of the form to CFMG.
- CFMG reviews non-urgent requests for approval or denial **within five (5) working days of receipt, and urgent requests 72 hours**.
- CFMG indicates the following information on the return correspondence:
    1. Authorization number
    2. Services approved for payment, i.e., surgical procedure, medical admission
    3. Physician authorized to provide care
    4. Authorized length of stay for inpatient admissions
- CFMG notifies the member and/or physician of the authorization or denial.
- Approved authorizations are valid for ninety (90) days, or as specified, from the date of approval.
- CFMG issues certification of an extended hospital stay following concurrent review.
- CFMG, Hospital Discharge Planner and Physician coordinate home care with contracted providers as medically necessary.

We will be unable to process incomplete and illegible requests. Please complete form with full clinical information and include copy of chart notes.

NOTE: Refer to California Children Services (CCS) for authorization, if the member has an eligible CCS condition/diagnosis.

Home Care, Durable Medical Equipment Orthotics and Prosthetics

Elective Procedures or Admissions:

- **Primary Care Physician** or Specialist completes a Request for Authorization Form.
- Following evaluation, Physician completes the Request for Authorization Form and faxes to CFMG to request services.
- CFMG reviews non-urgent requests for approval or denial **within five (5) working days of receipt, and urgent requests within 72 hours**.
- CFMG authorizes services with contracted home health agency, durable medical equipment company, or orthotic/prosthetic supplier.

- CFMG notifies the member, physician, and provider of service of the authorization or denial.
- Agency/provider must contact CFMG for extension of referral.
- Agency/provider reports results to physician.

We will be unable to process incomplete and illegible requests. Please complete form with full clinical information and include copy of chart notes.

NOTE: Refer to California Children Services (CCS) for authorization, if the member has an eligible CCS condition/diagnosis.

Rehabilitation Services

Elective Procedures or Admissions:

- **Primary Care Physician** or Specialist completes the **Request for Authorization Form**.
- Following evaluation, Physician completes the **Request for Authorization Form** and faxes to CFMG to request services.
- CFMG reviews non-urgent requests for approval or denial **within five (5) working days of receipt, and urgent requests within 72 hours**.
- CFMG notifies the member, physician and therapist of the authorization or denial.
- Therapist reports improvement, outcome expectations, duration and frequency of treatment to Physician.
- Physician or therapist completes **Request for Authorization Form** to request additional rehabilitation services. Include patient improvement, outcome expectations, duration and frequency of treatment. Physician or therapist faxes and/or mails a copy of the form to CFMG.
- CFMG reviews concurrent requests for approval or denial **within five (5) working days, consistent with the urgency of Member's medical condition**.
- CFMG notifies the member, physician, and therapist of authorization or denial.
- If approved, member schedules appointment to receive additional therapy. Therapist notifies physician of outcome.

Rehabilitation Services may not be provided by the Primary Care Physician or Specialist without prior authorization.

We will be unable to process incomplete and illegible requests. Please complete form with full clinical information and include copy of chart notes.

NOTE: Refer to California Children Services (CCS) for authorization, if the member has an eligible CCS condition/diagnosis.

Benefit Exclusions

Excluded Services and Programs

The following services will be "carved out" from the Alameda Alliance for Health and Anthem Blue Cross Medi-Cal Scope of Benefits:

1. California Children's Services (CCS).
2. Mental Health Services including drug abuse and alcoholism treatment programs.
3. Long-term care in intermediate facilities following the month of admission, and the first month thereafter.
4. Home and Community-Based Waived Services.
5. Major organ transplants (bone marrow, heart, liver, lung, heart/lung, combined liver and kidney, combined liver and small bowel).

Exclusions

- The complete list of benefits covered by Medi-Cal is set forth in Title 22 of the California Code of Regulations. Medical services not included in Title 22 are an exclusion of the benefit.
- The Medi-Cal program does not cover experimental services. "Experimental services" means those drugs, equipment, and procedures that are being tested in the laboratory and/or involved in animal studies before being tested in humans.
- Services that are not medically necessary.

California Children's Service (CCS)

CFMG members, ages 0 through 20 can receive care through California Children's Services (CCS) for specific eligible conditions (see below). CCS financial eligibility is automatic when member has Medi-Cal coverage.

Providers who know that the member has a CCS-eligible condition and/or an open case being managed by CCS should obtain authorization for services for that condition directly from CCS. Instructions for referrals and claims can be found online at
www.dhcs.ca.gov/services/ccs/Pages/default.aspx

If the condition is not CCS-eligible or if CCS eligibility is uncertain, providers should follow the CFMG authorization procedures.

Eligible CCS Conditions

Learn more on DHCS website: www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx

CCS usually covers the following conditions. Other conditions may be eligible if they involve disability and should also be referred to CCS. **Please note: This list is not inclusive.**

- Orthopaedic conditions due to infection, injury, or congenital malformations
- Conditions requiring plastic reconstruction, such as cleft lip, oral-facial anomalies, and burns
- Conditions requiring orthodontic reconstruction, such as cleft palate, severe malocclusion, oral-facial anomalies
- Eye conditions leading to a loss of vision (ordinary refractive errors are excluded)
- Ear conditions leading to a loss of hearing
- Rheumatic fever
- Nephritis, nephrosis, or the nephritic syndrome
- Phenylketonuria
- Hemophilia
- Hyaline membrane disease
- Endocrine and/or metabolic disorders posing medical management problems of diagnosis
- Convulsive disorders
- Blood dyscrasias
- All neoplasms
- Severe skin disorders such as epidermolysis
- Chronic pulmonary conditions such cystic fibrosis, bronchiectasis, and lung abscess
- Congenital anomalies causing disabling or disfiguring handicaps
- Asthma, with chronic lung disease
- Diabetes – Type I
- Conditions of the nervous system such as inflammatory disease of the central nervous system which produces motor disability such as paralysis, ataxia, etc., and neuromuscular disease such as cerebral palsy and muscular dystrophy
- Conditions resulting from accidents or poisoning which may be potentially handicapping, such as complicated fractures, brain and spinal cord injuries, stricture of the esophagus
- Other disabling or disfiguring conditions which are handicapping

Establishing a CCS Case

Referrals to CCS may be made by anyone including, but not limited to, the family, school or public health nurse, social worker or primary care physician. It is recommended that the provider contact the CCS County Office that the member resides.

For Alameda County residents, please contact the CCS County Office at:

Alameda County CCS
1000 Broadway, Ste. 500
Oakland, CA 94607
(510) 208-5970

For Contra Costa County residents, please contact the CCS County Office at:

Contra Costa County CCS
1220 Morello Ave., Ste. 101
Martinez, CA 94553
(925) 313-6400

While any provider, parent, social worker, or teacher may contact CCS to establish a CCS case, CFMG referral procedures will apply if CCS does not accept the case. Either a CCS referral or a CFMG authorization must be in place for any services to be covered.

Contacting CCS is not an authorization of service but does establish the earliest date for which eligibility may apply and begins the process of opening the case.

Referral through CFMG

PCPs that identify a condition, which may require CCS services, should complete either:

- A **Specialty Referral Form** for the specialist consult that may be authorized by the PCP.
- A **Request for Authorization Form** for other services, such as diagnostic testing, DME, inpatient stays, and outpatient procedures/services.

Submit the **Request for Authorization Form** to CFMG, the **Specialty Referral Form** to the specialist. Completion of the form ensures that the provider will be paid by the plan if the condition is not medically eligible for CCS. Indicate on the forms that a referral to CCS is requested.

Members can begin care with the specialist immediately. Providers do not have to wait for CCS to determine eligibility because the services have been authorized by CFMG or the PCP.

Direct Referral to CCS

Providers can contact CCS directly; the following information is required or a referral form from CCS should be completed:

- Patient name
- Date of birth
- Medi-Cal number
- Name, address, telephone number of parent or legal guardian
- Address and telephone of child, if different
- Medical condition
- Referring provider's name and phone number

The information may be faxed or mailed to the CCS County Office where the patient resides. Identify the specialist for referral, if any. CCS will honor your request if the physician is CCS-paneled. Referrals should be made to specialists in the Alameda Alliance for Health and Anthem Blue Cross networks who are also CCS paneled.

Providers should also forward copies of medical reports that support the CCS-eligible condition or suspected condition. In addition to a history and physical, these might include laboratory test results, diagnostic imaging reports, operative, or pathology reports.

Coordination of Care

Children with CCS-eligible conditions should still see their PCP for routine care, urgent care of non-eligible conditions, and for preventive care, including immunizations.

CFMG relies on PCPs to coordinate services with CCS specialty providers. If the member is eligible for CCS services, CCS will provide medical case management for the specific CCS condition. In all cases, PCPs must continue to provide primary case management to the member.

Claims

If the specialist has received CCS authorization for services, and there is a **Service Authorization Request (SAR)**, the specialty provider should submit claims for payment directly to the fiscal intermediary.

If a claim is submitted and denied by CFMG using adjustment code UDS = CCS Primary, the specialty provider must submit the claim directly to CCS for payment. If CCS denies the claim, it can then be appealed to CFMG with a copy of the CCS denial.

New CCS/Client Service Authorization Request (SAR) (PDF)

Established CCS/Client Service Authorization Request (SAR) (PDF)

Laboratory Services

Outpatient laboratory services can be provided through Quest Diagnostics and UCSF Benioff Children's Hospital Oakland Laboratory ("UCSF Benioff Children's Hospital Oakland Laboratory"). Providers should send members or specimen to Quest Diagnostics or UCSF Benioff Children's Hospital Oakland Laboratory for all laboratory testing except:

- Tests included in the PCP capitation contract
- Genetic, chromosomal, and alpha-fetoprotein prenatal testing

These tests are provided through alternative sites described in the following pages.

UCSF Benioff Children's Hospital Oakland (BCH Oakland) Laboratory Services

Most outpatient laboratory work may be performed at BCH Oakland Laboratory including, but not limited to, family planning, sensitive services, and lead testing.

BCH Oakland Laboratory Services include:

- Two to four hours STAT testing services
- Client Services available 24 hours a day, 7 days a week

BCH Oakland Laboratory is conveniently located at the Out Patient Center (OPC) on the first floor at 744 52nd St., Oakland, CA 94609. Physicians may contact the BCH Oakland Laboratory at **(510) 428-3525**. There is also a draw station on the first floor of the OPC.

Quest Diagnostics Services

Quest Diagnostics services and programs include:

- Two to four hours STAT testing services
- Quest Express – same day testing service
- Client Services available 24 hours a day, 7 days a week
- Courier Services
- Supplies
- Custom ICD-10 Requisition Program
- Find a draw station **(888) 277-8772 or** www.questdiagnostics.com

Quest Diagnostics Client/Patient Services

Quest representatives are available Monday through Friday at **(866) 697-8378** or at the specific departments listed below:

Client Services
(Results, specimen request, pricing)
(866) 697-8378

Patient Billing Inquiries
(855) 324-2016

Laboratory Claims

Quest and UCSF Benioff Children's Hospital Oakland are Alameda Alliance for Health (AAH) and Anthem Blue Cross contracted partners for most outpatient clinical laboratory services. For information on providing or ordering laboratory services, please call the Alameda Alliance for Health at **(510) 747-4510**; for Anthem Blue Cross, please call **(800) 407-4627**.

PCPs must submit encounter data to CFMG for all capitated laboratory services (see Table on next page). PCPs may not bill for non-capitated laboratory procedures performed in their office on their assigned members. Any services that fall outside of the capitated list below should be directed to Quest Diagnostics.

PCP Capitated Laboratory Procedures

Code	Description
81000	Urinalysis with microscopy
81002	Urinalysis without microscopy
81007	Urine test for Bacteria
82270	Test feces for Blood
82948	Blood glucose test, reagent strip
82954	Assay Urine Glucose
84703	Pregnancy Test
85014	Hematocrit
85018	Hemoglobin, Calorimetric
87082	Culture Screen of Specimen by Kit, Single Organism
87210	Wet Mount with Simple Stain for Bacteria, Fungi, Starch
89205	Occult Blood Test
Z5218	Collection/Handling of Blood/Specimen
Z5220	Collection/Handling of Blood/Specimen – Other Physician Services

Billing Exceptions

Certain procedures do not have to be referred to Quest Diagnostics and may be billed fee-for-service. These include:

- Genetic testing
- Perinatal testing
- HIV, family planning and STD testing, or Minor Sensitive Services, when ordered by a provider other than the assigned PCP

ALAMEDA Alliance FOR HEALTH

CHILDREN FIRST MEDICAL GROUP

Alameda Alliance for Health

Medi-Cal

Medi-Cal is a federal and state funded health insurance program for low-income families and children, persons with disabilities, and seniors who qualify for help. Eligibility and enrollment services are provided by the Alameda County Social Services Agency.

Newborns born to Medi-Cal members are covered for the month of and the month following of life through Alameda Alliance for Health.

The Medi-Cal Managed Care plan will be administered by Children First Medical Group, Inc. All professional claims should be submitted electronically with payer # 94321 or to CFMG Claims Department at:

Children First Medical Group, Inc.
Attn: Claims Department
P.O. Box 99680
Emeryville, CA 94662-9680

All facility claims should be submitted to Alameda Alliance for Health

Alameda Alliance for Health
P.O. Box 2460
Alameda, CA 94501-0460

For information regarding physician reimbursement for Alameda Alliance for Health Medi-Cal members, please contact CFMG's Customer Service at **(510) 428-3154**.

Alameda Alliance for Health Member Rights and Responsibilities

CFMG is committed to ensuring that Alameda Alliance for Health members receive the highest quality care and services, and that care is provided in a culturally competent/non-discriminatory manner. CFMG strives to preserve its mission statement, in which medical treatment is delivered in a professional manner that respects each member's rights. These Members Rights and Responsibilities should be posted in all waiting areas and a written copy will be provided to members upon request.

Member Rights

As an Alameda Alliance for Health member, you have the right to:

1. To receive information and advice about the Alameda Alliance for Health, its programs, its doctors, the healthcare network, Advance Directive, and their rights and responsibilities.
2. 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.

3. To be treated with respect at all times.
4. To choose a PCP within the Alameda Alliance for Health's network and help make choices about their health care with their doctor.
5. To talk freely with their doctors about treatment options for their health and help make choices about their health care with your doctor this includes the right to refuse treatment.
6. To voice complaints (grievance) about the Alameda Alliance for Health, its doctors, or the care the Alameda Alliance for Health provides, or ask for a State Medi-Cal Fair Hearing.
7. To receive translation and interpreter services and written information in other formats (audio, braille, large size print, etc.).
8. To access covered Federally Qualified Health Centers, American Indian Health Programs, sexually transmitted disease services, emergency services and family planning services outside the Alameda Alliance for Health's network, Minor Consent Services, and specialty services (i.e., Durable Medical Equipment (DME)).
9. To leave the Alameda Alliance for Health upon request at any time, subject to any restricted disenrollment period.
10. To continue to see their doctor if you are no longer covered by the Alameda Alliance for Health under certain circumstances.
11. To be free from any form of restraint or rejection used as a means of pressure, discipline, convenience, or retaliation.
12. To use these rights freely without changing how they are treated by the Alameda Alliance for Health, doctors, the health care network, or the State.
13. To access the Alameda Alliance for Health Nurse Line, 24/7 toll-free at **(888) 433-1876**.
14. To access telephone triage or screening 24/7 by calling their PCP.

Member Responsibilities

The Alameda Alliance for Health is responsible for providing members with access to medically necessary covered services in a timely manner. Alameda Alliance for Health members have certain responsibilities as well.

1. To treat all the Alameda Alliance for Health staff and health care staff with respect and courtesy.
2. To give their doctors and the Alameda Alliance for Health correct information.
3. To work with their doctor. Learn about their health and help to set goals for their health.
4. To always present their Alameda Alliance for Health Member Identification Card to receive services.
5. To ask questions about any medical condition, and make sure they understand their doctor's reasons and instructions.
6. To help Alameda Alliance for Health maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
7. To make and keep medical appointments and inform their doctor at least 24 hours in advance when they need to cancel an appointment.

8. To use the emergency room only in case of an emergency or as directed by their doctor.

(Source of Member's Rights and Responsibility – Alameda Alliance for Health Provider Manual, August 2020)

Member rights and responsibilities are communicated to all participating providers in the Providers Manual. Member's Rights and Responsibilities are communicated to the member upon enrollment with their Health Plan.

References:

NCQA standards for Member's Rights and Responsibilities
Alameda Alliance for Health

Complaints and Grievance Procedures for Members

The philosophy for complaints and grievances is founded on fairness communication, and problem solving. Our goal is to keep both members and providers satisfied.

Member and provider concerns are taken seriously. The grievance policy ensures that complaints and formal grievances are addressed in a timely manner. This process is in accordance with state regulations and provides an opportunity for all sides to be heard and adequate opportunities for appeal.

Most problems and complaints will be resolved informally. However, the formal grievance process may be utilized when resolution cannot be reached informally. Provider(s) and/or the member's legal representative may act on behalf of the member as appropriate.

A provider aware of a member with a problem or complaint about AAH should follow the following procedures:

- All complaints are reported to Alameda Alliance for Health according to our contractual agreement.
- Have the member call the Member Service Department at **(510) 747-4567**.

The Children First Medical Group staff will work with Alameda Alliance for Health to provide for a timely and organized system for resolving a member's complaint and/or grievances.

For Alameda Alliance for Health members assigned to CFMG contracted providers please call Member Service Department at **(510) 747-4567**.

Alameda Alliance for Health Eligibility Protocols

How to Identify Alameda Alliance for Health Members

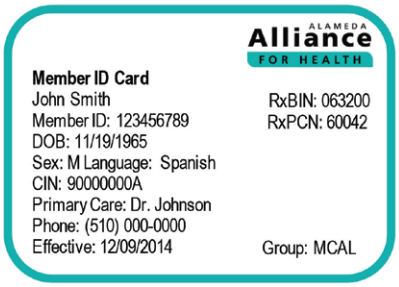
Identifying Alameda Alliance for Health members is a two-step process:

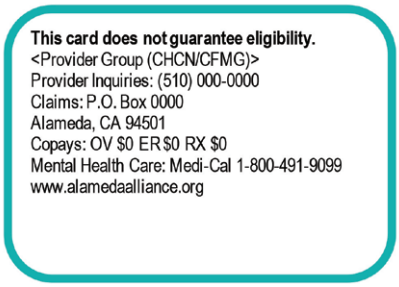
1. Log on to the Alameda Alliance for Health web site: www.alamedaalliance.org/providers and check eligibility.

2. Make sure the child is assigned to your CFMG physician (if you're the PCP office). Check the Alameda Alliance for Health ID card for your physician's name, your capitation eligibility reports or the online Alameda Alliance for Health eligibility website.
3. Alameda Alliance for Health Automated Eligibility Line – Please have your NPI or Tax ID. Available 24 hours a day, 7 days a week. Phone: **(510) 747-4505**.
    a. **Note: CFMG physician is identified on the Alameda Alliance for Health ID card with the notation Children First (or CFMG)**
4. For specialist, make sure you have a referral from correct PCP on the Alameda Alliance for Health ID card.
5. If unable to confirm eligibility, check Medi-Cal website for different spelling of name or call:
    a. CFMG Customer Service at **(510) 428-3154**.
    b. Alameda Alliance for Health at **(510) 747-4505**.

Medi-Cal Benefits Identification Card

Included in the Miscellaneous Section is an enlarged sample of the Medi-Cal Benefits Identification Card (BIC) issued by the State of California. It is plastic and has electronic "swipe" capability. This card by itself is for identification purposes only. It must be compared with information from the Health Plan or their web site in order to confirm eligibility with Medi-Cal managed care.





Verifying Newborn Services

Newborns born to mothers who are Alameda Alliance for Health members are covered by Alameda Alliance for Health for the calendar month of birth and the month following ("newborn period"). During this newborn period, the baby is covered under the mother's Medi-Cal benefits.

Specifics of Newborn Coverage:

- If the mother does not apply for the baby to receive its own Medi-Cal benefits, the baby will not be eligible for Medi-Cal services, including Alameda Alliance for Health services.
- After the newborn period occurs, providers will not receive reimbursement or capitation for the baby from the Alameda Alliance for Health.
- Alameda Alliance for Health sends reminders regarding newborn eligibility to the mother and can assist by providing enrollment information. However, providers are encouraged to also remind the parent/guardian to obtain separate Medi-Cal benefits for the newborn and to choose a health plan and a PCP for continuity of care.

Alameda Alliance for Health Benefits

Medi-Cal Covered Services

Medi-Cal's Scope of Covered Services includes all services which are set forth in Title 22 CCR 53210, as amended, subject to exclusions set forth in Section III, "Exclusions of this Exhibit." The Primary Care Physician shall provide or authorize the provision of said services. Those services include but are not limited to the following:

1. Physician Services:
    a. Outpatient physician services, including telehealth services.
    b. Outpatient surgical procedures.
    c. Physician services provided to hospital, skilled nursing facility, or intermediate care facility inpatients only during periods of facility stays covered by the program.
    d. Appropriate referrals to specialists.
    e. Well-woman exams including breast exam and routine gynecological care with Pap smear and pelvic exam, when acceptable to the patient.
    f. Topical Fluoride varnish for members younger than 6 years of age. This may be done up to 3 times in a 12-month period.
    g. Telephone calls, including 24 hour-a-day, 7 day-a-week call. Coverage arrangements by an alternate attending physician, not an emergency room.
    h. Supervision of physician assistants and advanced nurse practitioners, when supervised by the PCP.
2. Hospital Services:
    a. Outpatient department services.
    b. Inpatient care.
3. Emergency Services for immediate diagnosis and treatment for relief of severe pain to prevent disability or death.
4. Family Planning Services.
5. Pharmaceutical Services and prescribed drugs.
6. Laboratory and X-ray Services.
7. Child Health & Disability Prevention Program (CHDP) services for children under the age of 21. To become a CHDP provider please contact your local CHDP office.
8. Medical transportation services.
9. Durable Medical Equipment
10. Ancillary Services:
    - Optometry
    - Physical Therapy

- Speech Therapy
- Occupational Therapy
- Audiological Services
- Podiatry

11. Home Health.
12. Long-term care in intermediate and skilled nursing facilities, **first full month only**.
    - Interpreter Services

      If a provider is unable to provide language access for the member through his or her office's own resources, the Alameda Alliance for Health will assist with interpreter services at no cost to the provider or member. See quick reference guide.
13. Hospice and Palliative Care
14. Health Homes Programs
15. California Children's Services (CCS)

Topical Fluoride Varnish Resources

Resources for application of topical fluoride varnish for members younger than 6 years of age. This may be done up to 3 times in a 12-month period.

- **How to obtain fluoride varnish supplies** – Fluoride varnish can be ordered from many vendors in quantities from 32 to 200 packets. Ask your current vendor if they sell fluoride varnish or contact vendors listed below.
- **Young Specialties (800) 558-6684**
  www.youngspecialties.com
- **McKesson (855) 571-2100**
  mms.mckesson.com/catalog?query=fluoride+varnish

You may also want to do an internet search using the term, "fluoride varnish buy". There is an expiration date located on box and on each individual packet. Once product has expired the consistency may change and packets should be discarded.

Transportation Services

Medical Transportation Services

Medical transport is transport that is medically necessary. Benefits include:

Emergency Medical Transportation (EMT) – Ambulance transport to the nearest hospital is covered if the member has reason to believe that the medical problem is an emergency, and that the problem calls for emergency transport. This includes ambulance transport services supplied through the "911" emergency response system.

Non-Emergency Medical Transportation (NEMT) – NEMT includes transportation by ambulance, wheelchair vans, and gurney vans to or from Alliance-covered services and can be used when:

Medically Needed

– A member cannot use a bus, taxi, car, or van to get to their appointment because they require assistance to travel o Is requested by a treating physician; and

– Approved in advance and arranged by the Alliance's transportation vendor All requests for NEMT require prior authorization (PA). The transportation must be certified as medically necessary by a physician treating the member. Members or providers can request NEMT by faxing the Physician Certification Statement (PCS) form to the Alliance's transportation vendor at **(877) 457-3352** and calling toll-free at **(866) 529-2128 for assistance at least seven (7) business days before the scheduled appointment and as soon as possible in the case of urgent appointments.**

Here is the link to the **Physician Certification Form – Request for Transportation:** alamedaalliance.org/wp-content/uploads/PCS-Transportation-Form_EN_02012021-clean.pdf

Hospital discharges must be arranged at least four (4) hours in advance. The Alliance will approve only the lowest-cost type of NEMT that is adequate for the member's medical need and is available at the service level required.

Non-Medical Transportation (NMT)

NMT includes transportation by public transportation, taxi, or other car to Medi-Cal-covered services can be used when:

– A member is able to travel without assistance but requires transportation to or from services covered by Medi-Cal; and

– Approved in advance and arranged by the Alliance's transportation vendor.

Requests for NMT may require PA but do not require a physician's signature. Members or providers can request NMT by completing the PCS form and faxing it to the Alliance's transportation vendor at **(877) 457-3352** or by calling toll-free at **(866) 529-2128** to request for services.

For more information, please see Alameda Alliance Provider Manual, page 98
https://alamedaalliance.org/wp-content/uploads/Provider-Manual_10072021-clean.pdf

Alameda Alliance for Health Interpreter Services

Requesting Interpreter Services

Alameda Alliance for Health provides no-cost interpreter services including ASL for all Alliance-covered services, 24 hours a day, 7 days a week. Please confirm the member's eligibility before requesting services.

Telephonic Interpreter Services

To access telephonic interpreters:

1. Please call **(510) 809-3986, available 24 hours a day and 7 days a week.**
2. Enter your **PIN (CFMG -1002).**
3. Provide the nine-digit Alliance member ID number.
4. For communication with a patient who is deaf, hearing, or speech impaired, please call the California Relay Service (CRS) at 711.

In-Person Interpreter Services

Members can receive in-person interpreter services for the following:

- Sign language for the deaf and hard of hearing.
- Complex courses of therapy or procedures, including life-threatening diagnoses (examples: cancer, chemotherapy, transplants, etc.).
- Highly sensitive issues (examples: sexual assault or end of life).
- 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.
2. Please complete and fax the **Interpreter Services Appointment Request Form** to Alameda Alliance for Health at **FAX: (855) 891-9167**. To view and download the form, please visit www.alamedaalliance.org/providers/provider-forms.
3. The Alliance will notify providers by fax or phone if for any reason they can't schedule an in-person interpreter.
4. If needed, please cancel interpreter services at least 48 hours prior to the appointment by calling the Alameda Alliance for Health Provider Services Department at **(510) 747-4510**.

Video and Conference Platform Interpreter Services

For more information on video interpreters and telehealth visits using online platforms, please email interpreters@alamedaalliance.org.

For more information, please call:

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

Phone Number: **(510) 747-4567** or Toll-Free: **(877) 932-2738**

People with hearing and speaking impairments (CRS/TTY): **711/(800) 735-2929**

Alameda Alliance for Health Vision Services

Coverage

March Vision Care provides coverage for the management of ocular or systemic conditions that produce ocular or visual symptoms. It also covers the management of certain progressive conditions that are associated with potential vision loss.

Medi-Cal members access vision care services through March Vision Care providers, please visit their website at **www.marchvisioncare.com**. The member is allowed to self-refer to any March Vision provider that is listed at **www.marchvisioncare.com/find.aspx**.

The directory is sent to each new Alameda Alliance for Health member upon enrollment into the Medi-Cal Managed Care plan. If a member has questions regarding the March Vision Care Provider Network, they can call **(844) 336-2724**.

Basic member benefits include one (1) routine eye examination with refractive services and prescriptions eyewear every two years. Additional services and lenses are provided based on medical necessity for examinations and new prescriptions.

Alameda Alliance for Health Billing and Claims Process

Our EDI payer # 94321
Professional Claims Billing Address:
Children First Medical Group, Inc.
Attn: Claims Department
P.O. Box 99680
Emeryville, CA 94662-9680

Claim Form

Submit claims using the CMS-1500 form (See Miscellaneous Section). If this form is not utilized, your form must contain the same information as the CMS-1500.

Billing Format Requirements

The following information must be included on the claim:

1. Member's name.
2. Member's Identification number.
3. Member's date of birth.
4. Health plan name.
5. Tax Identification Number (TIN) of the physician or group performing the service(s).
6. ICD-10 diagnostic codes.

7. Procedure codes (CPT) with modifiers, where appropriate.
8. Coordination of benefits information regarding other insurance coverage that may be applied to the member.
9. Referring primary care physician (if a specialist claim).
10. Date(s) of service.
11. National Provider Identifier (NPI) number of the provider who is performing the services(s).
12. Physicians on call for another physician must indicate in Section 17 "On call for Dr. _____."
13. Authorization number for services requiring prior authorization. (box 63 of the UB-92 form/box 23 of the CMS-1500 form)

Billing Members

By entering into agreement with CFMG, you have agreed to look to CFMG exclusively for payment of covered services provided to members. Payment from CFMG represents payment in full for services. You may not bill health plan members for the difference between actual charges and the reimbursed amount. You must bill CFMG directly and may not bill the member except for co-payments (where applicable) and services not included within the benefit package.

Under the Knox-Keene Act, Health and safety code 1379 of the State of California, it is illegal to bill a member who is enrolled in a state program for which services were provided.

Co-Payments

Medi-Cal Managed Care members do not have a co-payment requirement at this time.

Submission of Claims/Timely Filing Limit

Providers have 180 days from the date of service to submit claims. Exceptions to this policy are Coordination of Benefits (COB) claims or Third-Party Liability claims.

Provider Information Change

Please notify CFMG immediately if there are any changes in the provider's Tax ID Number, the billing address, or provider office location. All changes must be submitted in writing and may be faxed to CFMG Provider Relations at **(510) 450-5668** or mail to:

Children First Medical Group, Inc.
Attn: Provider Relations
6425 Christie Ave., Ste. 110
Emeryville, CA 94608-2245

Coordination of Benefits (COB)

Members may have medical coverage through more than one health plan. If you determine that another healthplan/payor has the primary responsibility for payment of services, claims should be submitted to hat healthplan/payor first before sending the claims to CFMG for payment.

Explanations of Benefit (EOB)

You will receive an EOB that provides an explanation of the following:
1. Total billed charges
2. Paid amount
3. Member responsibility
4. Provider adjustment

Explanations of Benefits (EOB) Description	
Field	**Explanation**
Vendor Number:	Provides the vendor number assignment in EZ-Cap, the payee name and address.
Provider Name:	Provides the name of the physician that actually performed the services.
Check Number:	Number assigned to check.
Date Paid:	Reflects the date the check was issued.
Member ID:	Indicates the unique number assigned to the member by the Health Plan.
HP Code:	Indicates the Health Plan code assigned to the member in EZ-Cap.
Account Number:	Account number assigned to member from the provider office
Member Name:	Indicates the name of the patient.
Claim Number:	Indicates the claim number assigned in EZ-Cap to the submitted CMS-1500 or UB92.
Service Date:	Indicates the line item date of service submitted on the original claim form.
Provider:	Name of provider of service.
Procedure Description:	Indicates the line item CPT code and its corresponding description submitted on the original claim form.
Billed Amount:	Indicates the line item dollar amount submitted on the original claim form.
Contract Amount:	Indicates the contract allowable amount for the procedure code submitted on the original claim form.
Co-pay:	Indicates the amount of the patient's co-payment, if any, for the procedure code submitted on the original claim form.
Adjust:	Indicates any adjusted dollar amount made to the line item.
CD:	Adjustment code: indicates the definition of how claim was processed.
Amount Withheld:	Field not currently used.
Net Payment:	Indicates the net payment amount for the line item submitted on the original claim form. (Contract amount minus co-pay or adjustment equals net payment.)
Vendor:	Payee.

Adjustment Codes and Reasons

Adjustment Codes and Reasons (PDF)

Procedure Code Modifiers

Anesthesia Guidelines Physical Status Modifiers

Modifier	Description	Additional Base Units Reimbursed
P1	A normal healthy patient	No Additional Base Units
P2	A patient with mild systemic disease	No Additional Base Units
P3	A patient with severe systemic disease	2.0 Additional Base Units
P4	A patient with severe systemic disease that is a constant threat to life	2.0 Additional Base Units
P5	A moribund patient who is not expected to survive without the operation	4.0 Additional Base Units
P6	A declared brain-dead patient whose organs are being removed for donor purposes	No Additional Base Units

The above six levels are consistent with the American Society of Anesthesiologists (ASA) ranking of patient physical status. Base unit values payable is based on a $21.02 conversion factor for contracted providers and $14.01 conversion factor for non-contracted providers.

Physical Status Modifiers must be used in conjunction with the CPT to distinguish among the various levels of complexity of the anesthesia service provided, and to identify the service for additional reimbursement, Example: 00100-P1.

Qualifying Circumstances

More than one qualifying circumstance may be reported. Many anesthesia services are provided under particularly difficult circumstances depending on factors such as the condition of the patient, notable operative conditions, or unusual risk factors. The following list of qualifying circumstances may be used to report situations that significantly impact on the character of the anesthesia service provided. These procedures may not be reported alone but should be reported as additional procedure codes qualifying an anesthesia service.

- 99100 – Anesthesia for patient of extreme age, under 1 year
  (For procedures performed on infants less than 1 year of age at time of surgery, see 00325, 00834, and 00836)
- 99116 – Anesthesia complicated by utilization of total body hypothermia
- 99135 – Anesthesia complicated by utilization of controlled hypotension

- 99140 – Anesthesia complicated by emergency conditions
  (An emergency is defined as existing when any delay in treatment of the patient would lead to a significant increase in the threat to life or body part. Any emergency condition must be specified).

Procedure Code Modifiers

Modifiers (PDF)

Level II HCPCS (National) Modifiers

Level II HCPCS (National) Modifiers (PDF)

Billing for Newborn Care

Submitting Claims for Newborn Care

Newborns born to mothers who are Alameda Alliance for Health members are covered by the Alameda Alliance for Health for the calendar month of birth and the month following (newborn period).

During the newborn period, the baby is covered under the mother's Medi-Cal benefits. Pediatricians will be paid by the health plan on a fee-for-service basis for attending the delivery, routine newborn care, and sick newborn care during the newborn period by the health plan. It is important to verify the mother's eligibility before providing service to the newborn.

Providers must correctly identify the newborn on the CMS-1500 form as follows:

- Enter the mother's name in field 9. Enter the mother's identification number in 1a.

  Claims should be submitted to:
  Alameda Alliance for Health
  Claims Department
  P.O. Box 2460
  Alameda, CA 94501-2460

Billing for Preventive Health Care

CFMG reimburses its providers fee-for-service for preventive health care examinations for Alameda Alliance for Health Medi-Cal Managed Care.

Preventive Health Care CPT Codes

The codes listed below apply for preventive health services for members with Alameda Alliance for Health Medi-Cal Managed Care.

Preventive Health Services – New Patient	
Procedure Code	**Description**
99381	Initial preventive medicine evaluation – under age 1
99382	Early childhood – (age 1 through 4 years)

99383	Late childhood – (age 5 through 11 years)
99384	Adolescent (age 12 through 17 years)

Preventive Health Services – Established Patients	
Procedure Code	**Description**
99391	Periodic preventive medical re-evaluation – under age 1
99392	Early childhood – (age 1 through 4 years)
99393	Late childhood – (age 5 through 11 years)
99394	Adolescent (age 12 through 17 years)

Billing for Immunizations

The billing procedures for reimbursement and/or administration of immunizations for Alameda Alliance for Health Medi-Cal Managed Care should be followed in order to ensure accurate and timely payment.

Billing Immunizations for Alameda Alliance for Health Medi-Cal Managed Care Members

PCPs have access to free vaccines through the Vaccines for Children (VFC) Program for Alameda Alliance for Health Medi-Cal Managed Care members. To enroll please contact the Child Health and Disability Prevention (CHDP) program directly for your county or city.

Alameda County (CHDP) **(510) 618-2070**
City of Berkeley (CHDP) **(510) 981-5300**

Administration and counseling of routine pediatric immunizations provided by VFC is reimbursed fee for service. The PCP should send a CMS-1500 to CFMG Claims Department in the following manner:

- Line item #1 – CPT code with a $0.00 billed amount
- Subsequent Line items – Administration & counseling code(s) with appropriate billed amount. These codes are paid fee-for-service.

Please note that non-VFC immunizations are reimbursed fee for service.

Providers must use the age appropriate Medi-Cal codes.

Alameda Alliance for Health Pharmacy Benefit

Effective Saturday, January 1, 2022, the Medi-Cal outpatient pharmacy benefit program is administered by the Department of Health Care Services (DHCS) through their PBM, Magellan Medicaid Administration, Inc. (Magellan). This is called "Medi-Cal Rx". Magellan will provide administrative services, as directed by the DHCS, including claims management, prior authorization (PA) and utilization management, pharmacy drug rebate administration, provider, and member support services and other ancillary and reporting services to support the administration of Medi-Cal Rx.

Alameda Alliance for Health will NO LONGER be the administrator for the pharmacy benefit.

For the first 180 days, effective January 1, 2022, no prior authorization (PA) is required for existing prescriptions without previously approved prior Authorization for drugs not on the Medi-Cal Contract Drug List. **After 180 days**, a PA must be submitted to Magellan.

Effective Saturday, January 1, 2022, providers may submit a PA to Magellan via the following:

- **Medi-Cal Rx Online Portal** – The prior authorization system information and forms will be available on the Medi-Cal Rx site at **www.medi-calrx.dhcs.ca.gov**
- **Fax: (800) 869-4325**
- **CoverMyMeds** - Providers can create an account and log in to submit a Prior Authorization on the CoverMyMeds website at **www.covermymeds.com**
- California Children's Services (CCS) program is part of Medi-Cal Rx.

Both providers and members that have questions can call the Medi-Cal member Help Line:

Magellan
Phone: (800) 977-2273
Website: www.Medi-CalRx.dhcs.ca.gov, click on Provider Portal
Beneficiary ID: Use the 14-character beneficiary identification number located on the front of the Benefits Identification card (BIC) or the Client Index Number (CIN) corresponding to the first nine charters of the beneficiary identification number.

Physicians must register for a pin code at: www.Medi-CalRx.dhcs.ca.gov; click on portal and then register. Providers will use their individual NPI numbers to register. The PIN number will be sent in the mail and could take up to 10 business days.

For more details see the Alameda Alliance for Health Provider Manual:
https://alamedaalliance.org/wp-content/uploads/Provider-Manual_10072021-clean.pdf
– see Pharmacy section


Anthem
BlueCross


CFMG
CHILDREN FIRST MEDICAL GROUP

Anthem Blue Cross

Medi-Cal

Medi-Cal is a federal and state funded health insurance program for low-income families and children, persons with disabilities, and seniors who qualify for help. Eligibility and enrollment services are provided by the Alameda and Contra County Social Services Agency.

Newborns born to Medi-Cal members are covered for the month of birth and the month following of life through Anthem Blue Cross. However, if the mother is an Anthem Blue Cross/CFMG member, then the newborn is covered for the month of birth and the month following through CFMG.

The Medi-Cal Managed Care plan will be administered by Children First Medical Group, Inc. All EDI claims should be submitted with payer I.D. # 94321. All paper claims for professional fees should be submitted to CFMG Claims Department at:

Children First Medical Group, Inc.
P.O. Box 99680
Emeryville, CA 94662-9680

Claims for facility fees should be submitted to Anthem Blue Cross.

Anthem Blue Cross Medi-Cal Managed Care
Claims Department
P.O. Box 60007
Los Angeles, CA 90060-0007

For information regarding physician reimbursement for Anthem Blue Cross members, please contact CFMG's Customer Service at **(510) 428-3154**.

If you have questions regarding Anthem Blue Cross medical services and/or prior authorization requests/inquiries, please contact CFMG's Utilization Management Department at:

Utilization Management

Hours:	**8:00 am – 5:00 pm**
Telephone:	**(510) 428-3489**
FAX:	**(510) 450-5868**

Anthem Blue Cross Member Rights and Responsibilities

CFMG is committed to ensuring that Anthem Blue Cross members receive the highest quality care and services, and that care is provided in a culturally competent/non-discriminatory manner. CFMG strives each day to preserve its mission statement, in which medical treatment is delivered in a professional manner that respects each member's rights. These Members Rights and Responsibilities should be posted in all waiting areas and a written copy will be provided to members upon request.

Member Rights

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its providers and services, including covered services and member rights and responsibilities.
- To be able to choose a primary care provider (PCP) within Anthem Blue Cross' network.
- To have timely access to network providers.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To ask for an appeal of decisions to deny, defer, or limit services or benefits.
- To get care coordination.
- To get free oral interpretation services for your language.
- To get free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with Anthem Blue Cross and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
- To disenroll from Anthem Blue Cross and change to another health plan in the county upon request.
- To access Minor Consent Services.
- To get written member-informing materials in alternative formats (such as braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & institutions Code Section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations 164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by Anthem Blue Cross, your providers, or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside Anthem Blue Cross network pursuant to the federal law.
- To make suggestions about Anthem Blue Cross' rights and responsibilities policy.
- To opt out of text communications from Anthem Blue Cross.

Member Responsibilities

- Contact your PCP right away to schedule your or your child's Initial Health Assessment (within 120 days of enrollment).
- Give us, your doctors, and other health care providers the information needed to help you receive the best possible care and all the benefits you are entitled to.
- Understand your health problems a well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Follow your doctor's advice about taking good care of yourself.
- Use the right sources of care.
- Bring your Anthem Blue Cross ID card with you when you visit your doctor.
- Treat your doctors and other caregivers with respect.
- Understand this health plan.
- Know and follow the rules of this heath plan.
- Know that laws govern this health plan and the types of service you receive.
- Know that we cannot discriminate against you because of your age, sex race, national origin, culture, language needs, sexual orientation, or health.

Source: Anthem Blue Cross Member Handbook, 3/2021, pages 66-68

Member rights and responsibilities are communicated to all participating providers in the Providers Manual. Member's Rights and Responsibilities are communicated to the member upon enrollment with their Health Plan.

References: Anthem Blue Cross Provider Manual
providers.anthem.com/docs/gpp/california-provider/CA_CAID_ProviderManual.pdf

Member Complaint and Grievance Procedure

The philosophy for complaints and grievances is founded on fairness, communication, and problem solving. Our goal is to keep both members and providers satisfied.

Member and provider concerns are taken seriously. The grievance policy insures that complaints and formal grievances are addressed in a timely manner. This process is in accordance with state regulations and provides an opportunity for all sides to be heard and adequate opportunities for appeal.

Most problems and complaints will be resolved informally. However, the formal grievance process may be utilized when resolution cannot be reached informally. Provider(s) and/or the member's legal representative may act on behalf of the member as appropriate.

A provider aware of a member with a problem or complaint about Anthem Blue Cross should follow the following procedure:

- All complaints/grievances are reported to Anthem Blue Cross according to our contractual agreement.
- To file a grievance by phone, members can call Anthem Blue Cross at **(800) 407-4627** to obtain the grievance form. Refer to the following website: mss.anthem.com/california-medicaid/benefits/medi-cal-plan-benefits.html. Select Other Resources (drop-down menu in the bottom right of the page), then select the language of the Member Grievances Form.
- To file a grievance in writing, members can call Anthem Blue Cross at **(800) 407-4627**, and request a grievance form. The member should complete and mail the completed grievance form to:

  Anthem Blue Cross
  P.O. Box 60007
  Los Angeles, CA 90060-0007
- An Anthem Blue Cross Grievance Coordinator will process and resolve the complaint.

Anthem Blue Cross Eligibility Protocols

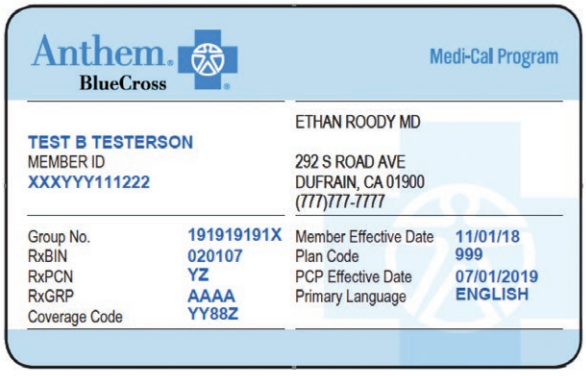
How to Identify Anthem Blue Cross Members

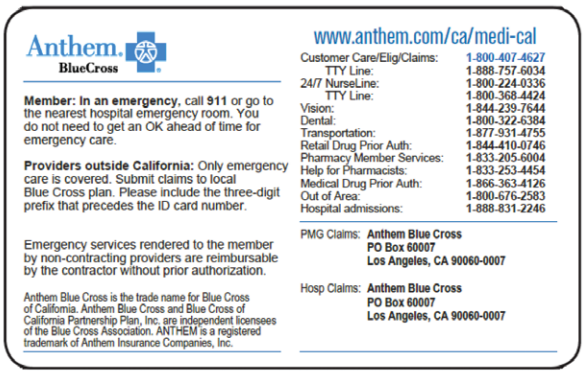
Identifying of Anthem Blue Cross member eligibility should be verified every visit:

1. Log on to the secure Availity website: www.availity.com or the Medi-Cal website: www.medi-cal.ca.gov/mcwebpub/login.aspx?ReturnUrl=%2feligibility
2. Make sure the child is assigned to your CFMG physician (if you're the PCP office) check for your physicians name on the ID Card.
3. If the information on the card is different from the website, please call to confirm eligibility:

   Anthem Blue Cross at **(800) 407-4627**.

Anthem Blue Cross MediCal Benefits Identification Card





Anthem Blue Cross Verification of Eligibility

How to verify eligibility:

Primary Care Physicians

All PCPs will receive a monthly computerized roster of members assigned to them. You can verify the eligibility of Anthem Blue Cross members by:

- Check the patient's BIC card: name, date of birth, sex; swipe the card.
- Check the patient's Anthem Blue Cross ID card.
- Compare card information with the computerized roster received from CFMG or Availity website: apps.availity.com/availity/web/public.elegant.login

Specialty Care Physicians

Specialty care for CFMG members requires referral by CFMG Primary Care Physicians for services that require authorization a request must be submitted to CFMG. CFMG utilization management staff will notify the PCP, SCP, and the member when the services have been authorized. Specialists should also ask to see the patient's identification card and confirm eligibility as above.

Note: CFMG physician is identified on the Anthem Blue Cross ID card with the name of Children First Medical Group.

Questions: If there is any question about a patient's eligibility, call CFMG Customer Service at **(510) 428-3154** or the Anthem Blue Cross Customer Service line at **(800) 407-4627**.

Verifying Newborn Eligibility

Babies born to mothers who are Anthem Blue Cross members are covered by Anthem Blue Cross for the calendar month of birth and the month following ("newborn period"). During the newborn period, the baby is covered under the mother's Medi-Cal benefits.

Newborns born to mothers who are CFMG Anthem Blue Cross members are covered by CFMG for the calendar month of birth and one month following (newborn period). Claims need to be submitted to CFMG directly.

If the mother does not apply for the baby to receive its own Medi-Cal benefits, the baby will not be eligible for Medi-Cal services, including Anthem Blue Cross services, after the newborn period. When this occurs, providers will not receive reimbursement or capitation for the baby from Anthem Blue Cross.

The Anthem Blue Cross sends reminders regarding newborn eligibility to the mother and can assist by providing enrollment information. However, providers are encouraged to also remind the parent/guardian to obtain separate Medi-Cal benefits for the newborn and to choose a health plan and a PCP for continuity of care.

Billing for Newborn Care

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

Providers must correctly identify the newborn on the CMS-1500 form as follows:

1. Enter the mother's name in box 4.
2. Enter the mother's ID number in box 1a.
3. Enter Mom's birth date in 11a.

Note: CFMG will forward any newborn claims that are the financial responsibility of the healthplan.

Anthem Blue Cross Benefits

Medi-Cal Covered Services

Medi-Cal Managed Care Scope of Covered Services includes all services that are set forth in Title 22 CCR 53210, as amended, subject to exclusions set forth in Section III, "Exclusions of this Exhibit." The Primary Care Physician shall provide or authorize the provision of said services. Those services include but are not limited to the following:

1. Physician Services:
    a. Outpatient physician services, including telehealth services.
    b. Outpatient surgical procedures.
    c. Physician services provided to hospital, skilled nursing facility, or intermediate care facility inpatients only during periods of facility stays covered by the program.
    d. Appropriate referrals to specialists.
    e. Well-woman exams including breast exam and routine gynecological care with Pap smear and pelvic exam, when acceptable to the patient.
    f. Topical Fluoride varnish for members younger than 6 years of age. This may be done up to 3 times in a 12-month period.
    g. Telephone calls, including 24 hours a day, 7 days a week calls. Coverage arrangements by an alternate attending physician, not an emergency room.
    h. Supervision of physician assistants and advanced nurse practitioners, when supervised by the PCP.
2. Hospital Services:
    a. Outpatient department services.
    b. Inpatient care.

3. Emergency Services for immediate diagnosis and treatment for relief of severe pain to prevent disability or death.
4. Family Planning Services.
5. Pharmaceutical Services and prescribed drugs.
6. Laboratory and X-ray Services.
7. Child Health & Disability Prevention Program (CHDP) services for children under the age of 21 and adult preventive care services.
8. Medical transportation services.
9. Durable Medical Equipment.
10. Ancillary Services:
    a. Optometry
    b. Physical Therapy
    c. Speech Therapy
    d. Occupational Therapy
    e. Audiological Services
    f. Podiatry
11. Home Health.
12. Long-term care in intermediate and skilled nursing facilities, **for the month of admission and the month after that**.
    - **Interpreter Services**

      If a provider is unable to provide language access for the member through his or her office's own resources, Anthem will assist with interpreter services. See information under "How to use Interpreter Services" in this manual.
13. Hospice and Pallative Care.
14. Health Homes Programs.
15. California Children's Services (CCS).

For a complete list of Benefits and Services (EOC) covered under Anthem Blue Cross, please see pages 40-68 of the member handbook: **https://mss.anthem.com/california-medicaid/caca_mc_memberhandbook_eng.pdf**.

Topical Fluoride Varnish Resources

Resources for application of topical fluoride varnish for members younger than 6 years of age. This may be done up to 3 times in a 12-month period.

- **How to obtain fluoride varnish supplies** – Contact a local pharmacy and submit a physician prescription.

Anthem Blue Cross Interpreter Services

The Medi-Cal population by nature is culturally and linguistically diverse. Anthem Blue Cross recognizes that this diversity sometimes serves as a barrier for Anthem Medi-Cal members and it affects the members' willingness to access all available services.

The responsibility of facilitating access for non-English speaking members lies on Anthem Blue Cross, not the members. Anthem Blue Cross does not require members to provide their own interpreter when utilizing services available to them through the Medi-Cal Program.

Anthem Blue Cross Medi-Cal provides a 24 hour interpreting service for our non-English speaking members who need assistance in understanding the program or communicating with their health care professional. Services are coordinated through the Dedicated Service Unit (DSU) and may be accessed by calling one of the following numbers:

8:30 am to 7:00 pm (PST)
(800) 407-4627
Medi-Cal Managed Care

After business hours please contact the Nurse Advice line:
(800) 224-0336

How to Use the Interpreting Service

Anthem Blue Cross contracts with a telephone interpreter service to provide interpreting assistance in the communication between physician and patient 24 hours a day, 7 days a week.

To use the interpreter service:

- Call the Anthem Blue Cross Dedicated Service Unit (DSU) number:

  8:30 am to 7:00 pm (PST)
  (800) 407-4627
  Medi-Cal

  After business hours please contact the Nurse Advice line:
  (800) 224-0336
- Give the representative the member's identification number.
- Explain the need for an interpreter and state the language.
- Wait on the line while the connection is made.
- Once connected to the interpreter, introduce the member, explain what help is necessary, and begin the dialog

Face-to-Face Interpreters Including Sign Language

Members and providers may call the Customer Care Center at **(800) 407-4627** to schedule services during business normal hours. 72 business hours are required to schedule services, and 24 business hours are required to cancel.

TTY and Relay Services (for members with hearing loss or speech impairment)

During normal business hours, call the Anthem Blue Cross TTY line at **(800) 735-2922**. After nosiness hours, members may call the Nurse Advice line TTY at **(800) 368-4424**.

Transportation Services

Non-Emergency Medical Transportation

Non-emergency medical transportation (NEMT), which may require prior authorization, allows members to be transported to medical appointments for covered services, transferred from a hospital to another hospital, facility or home. It is a covered service when all of the following criteria have been met:

- Medical necessity
- An Anthem Blue Cross provider requests the service
- The member is not able to use a bus, taxi, car or van to get to their appointment
- It is approved in advance by Anthem Blue Cross (when required)

ModivCare will help Anthem Blue Cross members manage their rides to and from medically necessary medical appointments including rides by livery, ambulette or mass transit.

Routine transportation is an Anthem Blue Cross value-added benefit, so there is no additional cost for this service to these members.

Members can call **(877) 931-4755** (Monday-Friday) to arrange for transportation through ModivCare at least 7 business days for new riders and 5 business days for existing riders.

Emergent Transportation – Ambulance Services

Ambulance services must come from a licensed ambulance or air ambulance company and be used only for emergencies. Coverage includes:

- Base charge and mileage
- Cardiac defibrillation
- CPR
- EKGs
- IV solutions
- Monitoring
- Oxygen
- Supplies

Anthem Blue Cross Vision Services

Coverage

Vision Service Plan (VSP) provides coverage for the management of ocular or systemic conditions that produces ocular or visual symptoms. It also covers the management of certain progressive conditions that are associated with potential vision loss.

Members access vision care services through VSP providers. The member is allowed to self refer to any VSP provider. If a member has a question regarding the VSP Provider Network, they can call VSP at **(800) 615-1883**.

Basic member benefits include one (1) routine eye examination with refractive services and prescription eyewear every two years. Additional services and lenses are provided based on medical necessity for examinations and new prescriptions.

VSP manages for the provision of optical lenses with the PIA Optical Laboratories. For additional information please visit: **www.vsp.com.**

Anthem Blue Cross Billing and Claims Process

Our EDI payer # 94321

Professional Paper Claims Billing Address:
Children First Medical Group, Inc.
Attn: Claims Department
P.O. Box 99680
Emeryville, CA 94662-9680

Claim Form

Submit claims using the CMS-1500 form (See Miscellaneous Section). If this form is not utilized, your form must contain the same information as the CMS-1500.

Billing Format Requirements

The following information must be included on the claim:

1. Member's name.
2. Member's ID Number.
3. Member's date of birth.
4. Health plan name.
5. Tax Identification Number (TIN) of the physician or group performing the service(s).
6. ICD-10 diagnostic codes.
7. Procedure codes (CPT) with modifiers, where appropriate.

8. Coordination of benefits information regarding other insurance coverage that may be applied to the member.
9. Referring primary care physician (if a specialist claim).
10. Date(s) of service.
11. License number of the provider who is performing the services(s).
12. Physicians on call for another physician must indicate in Section 17 "On call for Dr. _____."
13. Copy of **Specialty Referral Form** for specialty referrals. (initial visits only)
14. Authorization number for services requiring prior authorization. (box 63 of the UB-92 form/box 23 of the CMS-1500 form)

Billing Members

By entering into agreement with **CFMG**, you have agreed to look to **CFMG** exclusively for payment of covered services provided to members. Payment from **CFMG** represents payment in full for services. You may not bill health plan members for the difference between actual charges and the reimbursed amount. You must bill **CFMG** directly and may not bill the member except for co-payments (where applicable) and services not included within the benefit package.

Co-Payments

Medi-Cal Managed Care members do not have a co-payment requirement at this time.

Submission of Claims/Timely Filing Limit

Providers have 180 days from the date of service to submit claims. Exceptions to this policy are Coordination of Benefits (COB) claims or Third-Party Liability claims.

Provider Information Change

Please notify CFMG immediately if there are any changes in the provider's Tax ID Number, the billing address, or provider office location. All changes must be submitted in writing and may be faxed to CFMG Customer Service at **(510) 450-5668** or mail to:

Children First Medical Group, Inc.
Provider Relations Department
6425 Christie Ave., Ste. 110
Emeryville, CA 94608-2245

Coordination of Benefits

Members may have medical coverage through more than one health plan. If you determine that another healthplan/payor has the primary responsibility for payment of services, claims should be submitted to that healthplan/payor first before sending the claims to CFMG for payment.

Explanations of Benefits (EOB)

You will receive an EOB that provides an explanation of the following:
1. Total billed charges
2. Paid amount
3. Member responsibility
4. Provider adjustment

Explanations of Benefits (EOB) Description	
Field	**Explanation**
Vendor Number:	Provides the vendor number assignment in EZ-Cap, the payee name and address.
Provider Name:	Provides the name of the physician that actually performed the services.
Check Number:	Number assigned to check.
Date Paid:	Reflects the date the check was issued.
Member ID:	Indicates the unique number assigned to the member by the Health Plan.
HP Code:	Indicates the Health Plan code assigned to the member in EZ-Cap.
Account Number:	Account number assigned to member from provider's office
Member Name:	Indicates the name of the patient.
Claim Number:	Indicates the claim number assigned in EZ-Cap to the submitted CMS 1500 or UB92.
Service Date:	Indicates the line item date of service submitted on the original claim form.
Provider:	Name of provider of service.
Procedure Description:	Indicates the line item CPT code and its corresponding description submitted on the original claim form.
Billed Amount:	Indicates the line item dollar amount submitted on the original claim form.
Contract Amount:	Indicates the contract allowable amount for the procedure code submitted on the original claim form.
Co-pay:	Indicates the amount of the patient's co-payment, if any, for the procedure code submitted on the original claim form.
Adjust:	Indicates any adjusted dollar amount made to the line item.
CD:	Adjustment code: indicates the definition of how claim was processed.
Amount withheld:	Field not currently used.

Net Payment:	Indicates the net payment amount for the line item submitted on the original claim form. (Contract amount minus co-pay-adjusts equals net payment.)
Check Number:	Check number.
Vendor:	Payee.

Adjustment Codes and Reasons

Adjustment Codes and Reasons (PDF)

Procedure Code Modifiers

Procedure Code Modifiers

Level II HCPCS (National) Modifiers

Level II HCPCS (National Modifiers (PDF)

Anthem Blue Cross Billing for Newborn Care

Billing for Newborn Care

Newborns born to mothers who are Anthem Blue Cross members are covered by Anthem Blue Cross for the calendar month of birth and one month following ("newborn period"). During the newborn period, the baby is covered under the mother's Medi-Cal benefits. Pediatricians will be paid on a fee-for-service basis for attending the delivery, routine newborn care, and sick newborn care during the newborn period by Anthem Blue Cross. It is important to verify the mother's eligibility before providing service to the newborn.

Newborns born to mothers who are CFMG Anthem Blue Cross members are covered by CFMG for the calendar month of birth and one month following (newborn period). Claims need to be submitted to CFMG directly.

Providers must correctly identify the newborn on the CMS-1500 form as follows:

- Enter the newborn's name in box 2.
- Enter the mother's name in field 9 and box 4.
- Enter the mother's Identification number in box 1a.

Claims should be submitted to:
Anthem Blue Cross
Claims Department
P.O. Box 60007
Los Angeles, CA 90060-0007

Or if newborn's mother is a CFMG/Anthem Blue Cross member:
EDI payer # 94321

or

Children First Medical Group, Inc.
P.O. Box 99680
Emeryville, CA 94662-9680

Billing for Preventive Health Care

CFMG reimburses providers fee for service for preventive health examinations for Anthem Blue Cross.

Billing Preventive Health Services for Anthem Blue Cross Members

Anthem Blue Cross Preventive Health Services Codes

The codes listed below apply for preventive health services for members with Anthem Blue Cross.

Preventive Health Services – New Patient	
Procedure Code	**Description**
99381	Initial preventive medicine evaluation – under age 1
99382	Early childhood – (age 1 through 4 years)
99383	Late childhood – (age 5 through 11 years)
99384	Adolescent (age 12 through 17 years)
Preventive Health Services – Established Patients	
Procedure Code	**Description**
99391	Periodic preventive medical re-evaluation – under age 1
99392	Early childhood – (age 1 through 4 years)
99393	Late childhood – (age 5 through 11 years)
99394	Adolescent (age 12 through 17 years)

Billing for Immunizations

The billing procedures for reimbursement and/or administration of immunizations for Anthem Blue Cross should be followed in order to ensure accurate and timely payment.

Billing Immunizations for Anthem Blue Cross Members

PCPs have access to free vaccines through the Vaccines for Children (VFC) Program for Anthem Blue Cross Medi-Cal/CHDP providers. To enroll please contact the Child Health and Disability Prevention (CHDP) program directly for your county or city.

Alameda County (CHDP)	**(510) 618-2070**
City of Berkeley (CHDP)	**(510) 981-5300**
Contra Costa County (CHDP)	**(925) 313-6150**

Administration and counseling of routine pediatric immunizations provided by VFC is reimbursed fee for service. The PCP should send a CMS-1500 to CFMG Claims Department in the following manner:

- Line item #1 - CPT code with a $0.00 billed amount
- Subsequent Line items – Administration & counseling code(s) with appropriate billed amount. These codes are paid fee-for-service.

Please note that non-VFC immunizations are reimbursed fee for service.

Providers must use the age appropriate Medi-Cal codes.

Anthem Blue Cross Pharmacy Benefit

Effective Saturday, January 1, 2022, the Medi-Cal outpatient pharmacy benefit program is administered by the Department of Health Care Services (DHCS) through their PBM, Magellan Medicaid Administration, Inc. (Magellan). This is called "Medi-Cal Rx". Magellan will provide administrative services, as directed by the DHCS, including claims management, prior authorization (PA) and utilization management, pharmacy drug rebate administration, provider, and member support services and other ancillary and reporting services to support the administration of Medi-Cal Rx.

Anthem Blue Cross will NO LONGER be the administrator for the pharmacy benefit.

For the first 180 days, effective January 1, 2022, no prior authorization (PA) is required for existing prescriptions without previously approved prior Authorization for drugs not on the Medi-Cal Contract Drug List. **After 180 days**, a PA must be submitted to Magellan.

Effective Saturday, January 1, 2022, providers may submit a PA to Magellan via the following:

- **Medi-Cal Rx Online Portal** – The prior authorization system information and forms will be available on the Medi-Cal Rx site at **www.medi-calrx.dhcs.ca.gov**
- **Fax: (800) 869-4325**
- **CoverMyMeds** - Providers can create an account and log in to submit a Prior Authorization on the CoverMyMeds website at **www.covermymeds.com**

California Children's Services (CCS) program is part of Medi-Cal Rx.

Both providers and members that have questions can call the Medi-Cal member Help Line:

Magellan
Phone: (800) 977-2273
Website: www.Medi-CalRx.dhcs.ca.gov, click on Provider Portal
Beneficiary ID: Use the 14-character beneficiary identification number located on the front of the Benefits Identification card (BIC) or the Client Index Number (CIN) corresponding to the first nine charters of the beneficiary identification number.

Physicians must register for a pin code at: www.Medi-CalRx.dhcs.ca.gov; click on portal and then register. Providers will use their individual NPI numbers to register. The PIN number will be sent in the mail and could take up to 10 business days.

For more details see the Anthem Blue Cross Provider Manual:

https://providers.anthem.com/docs/gpp/california-provider/CA_CAID_ProviderManual.pdf
– see Pharmacy section