Section 3
The Role of the Primary Care Provider

Primary care providers (PCPs) are responsible for providing the full scope of primary care services to their Alliance members. As a PCP, your role is vital in the overall coordination of health care for each member in your practice, and in providing health care services. As a PCP, you are responsible for:

- Ensuring or facilitating members' access to the health care system, preventive care, and appropriate treatment interventions.
- Assessing each member's health status, including an Initial Health Assessment (IHA) for each new member within 120 days after his/her enrollment (see below).
- Providing quality primary care health services.
- Initiating and coordinating referrals to specialists or other participating providers as needed.
- Assuring that members in your practice are not discriminated against in the delivery of services based on race, ethnicity, national origin, spoken language, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, and/or source of payment.
- Assuring that no unnecessary or duplicate medical services are being provided. For additional information about unnecessary or duplicate medical services, see Policy 404-1108 - Monitoring of Over/Under Utilization of Services.
- Establishing a good medical records system for tracking, recall, and identifying any clinical problems unique to your particular patient population.
- Determining the number of Alliance members your practice can accept. The number of members linked to your practice will be monitored by the Alliance to ensure that members have timely access to care through credentialed providers. For more additional information on capacity and capacity monitoring see Policy 300-8040 - Monitoring PCP Capacity.

Facility Site Review and Medical Record Review

The Alliance conducts Facility Site Reviews (FSRs) for new Medi-Cal PCPs at the time of initial credentialing, at least every three years thereafter per California Department of Health Care Services (DHCS) guidelines, and as part of the re-credentialing process, regardless of the status of other accreditation and/or certifications. PCPs must notify the Alliance at least 30 days prior to a physical move or expansion of their clinic so an FSR may be conducted at the ~~new~~ site, as specified in Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. There are three components to the FSR process:

1. The Facility Site Review survey (MMCD PL 14-004 Attachment A).
2. The Medical Record Review survey (MMCD PL 14-004 Attachment B).

3. The Physical Accessibility Review survey (MMCD PL 14-004 Attachment C).

The FSR and the Medical Record Review (MRR) are scored reviews. The FSR reviews the physical aspects of the site for basic regulatory requirements in areas such as: access, safety, personnel, office management, infection control, and pharmaceutical/lab/preventive services. The MRR is conducted 90 to 180 calendar days after initial member linkage and focuses entirely on the medical record for format, documented evidence of coordination and continuity of care and appropriate preventive health care services provided. The Physical Accessibility Review (PAR) is not a scored review, and focuses entirely on physical accessibility of the clinic for all Alliance members, including Seniors and Persons with Disabilities (SPDs).

Any Corrective Action Plans (CAPs) that result from the scored reviews must be addressed within the established CAP timelines. The Alliance assists sites with their CAPs by providing education, answering questions, and offering resources whenever possible. Providers that do not meet CAP timelines, as specified in MMCD Policy Letter 14-004 timelines, are required to be removed from the network.

Additionally, provider sites that score 79% and below in either the FSR or the MRR may be removed from the network. Provider sites allowed to stay in the network will require verification of their CAP corrections and will not be assigned new members until their CAP is closed. Provider sites that receive two consecutive failing scores on either the FSR or MRR must score a minimum of 80% in their next FSR and MRR. Sites that do not score a minimum of 80% for the third consecutive review, are required to be removed from the network.

For more information on Facility Site Reviews, please see Policies 401-1508 - Facility Site Review Process and 401-1521 – Physical Accessibility Review.

The scoring sheets and standards for the FSR and MRR can be found on the Alliance provider website.

More information and the survey for the PAR can be found on our Physical Accessibility Review page on the provider website.

Primary Care Provider Selection

Every new Alliance Medi-Cal member will be provided an opportunity to select a PCP within the first 30 calendar days of enrollment. The member may communicate their PCP selection to the Alliance by phone, mail, fax, or through the Alliance website. If the member does not choose a PCP by the end of that period, they will be auto-assigned to a PCP. The auto-assignment logic looks at the following factors when doing PCP assignment: zip code, age, gender, language, family linkage and provider status. Alliance Care IHSS members are assigned to a PCP as of their effective date.

If an Alliance Medi-Cal member is eligible for the CCS program or receives Medi-Cal under an SPD aid code, they may choose a specialist as their PCP.

Initial Health Assessment

The Managed Care Quality Monitoring Division (MCQMD of the California Department of Health Care Services (DHCS) requires that each PCP complete an Initial Health Assessment (IHA) for all of his/her linked Medi-Cal members within 120 days of the member's enrollment. At a minimum, an IHA must include the following: comprehensive history, preventive services, comprehensive physical with mental status exam, diagnoses

and plan of care, and an Individual Health Education Behavioral Assessment (IHEBA) using the Staying Healthy Assessment (SHA) or other DHCS-approved tool.

The SHA and related instructions can be found on the Alliance IHA Resources Page and the CBI Resources Page.

Refer to MMCD Policy Letter 08-003 for requirements on IHA components. It is the providers' responsibility to code appropriately. Please visit the provider website for the 2018 IHA Billing Code List.

For more information on IHA criteria, please see Policy 401-1511 - Initial Health Assessment.

Early and Periodic Screen, Diagnosis and Treatment (EPSDT)

PCPs are required to ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

For more information on coordinating EPSDT services, please see Policy 404-1313 – Primary Care Provider Responsibilities in Case Management and the Promotion of Primary Care Medical Home.

Preventive Care

PCPs are required to provide preventive health care according to nationally recognized criteria. Please visit the provider website for assistance with preventive care guidelines for either children or adult patients. Alliance prevention guidelines for healthy, asymptomatic adults are based on the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF). All preventive services identified as USPSTF "A" and "B" recommendation must be provided. Alliance prevention guidelines for children are based on recommendations of the American Academy of Pediatrics (AAP) Bright Futures Guidelines and Child Health and Disability Prevention (CHDP) standards. Alliance immunization guidelines for adults and children are based upon recommendations of Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (CDC-ACIP).

For more information on Adult Preventive Care, please see Policy 401-1502 - Adult Preventive Care.

For more information on Child Preventive Care, please see Policy 401-1505 - Childhood Preventive Care.

For more information on Immunization Services and Reimbursement, see Policy 401-1506 – Immunization Services and Reimbursement.

For the CDC recommended immunization schedule for adults and children, please visit the CDC website.

Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions

As part of the comprehensive preventive care program, effective with dates of service on or after January 1, 2014, PCPs are required to offer Unhealthy Alcohol Use in Adolescents and Adults:Screening and Behavioral Counseling Interventions to all adult members (18 years and older) related to harmful alcohol use as

recommended by the US Preventive Services Task Force (USPSTF). Screening and behavioral counseling interventions should be provided to members who respond affirmatively to the alcohol pre-screen question on the SHA or those who the PCP otherwise identifies as having risky or hazardous alcohol use. For those members who respond affirmatively to pre-screening, the Alcohol Use Disorder Identification Test – Consumption (AUDIT-C) or other validated alcohol screening questionnaire should be administered. For members who respond affirmatively to the AUDIT-C or other validated screening tool, PCPs will offer alcohol use brief interventions (up to three 15 minute sessions in person or by phone) or refer members identified with possible alcohol use disorders to the alcohol and drug program in the county where the member resides for further evaluation and treatment.

Santa Cruz County Behavioral Health Access	(800) 952-2335 or (831) 454-4170
Monterey County Behavioral Health Access	(888) 258-6029 or (831) 755-5505
Merced County Behavioral Health Access	(888) 334-0163 or (209) 381-6880

Per United States Preventive Services Task Force (USPSTF) guidelines, providers should screen adults ages 18 years or older for harmful alcohol use. Each member is eligible for three screenings annually, as well as additional screenings if considered medically necessary. Brief intervention(s) typically include one to three sessions, and may be offered in-person, by telephone, or via telehealth. Members that are engaged in risky or hazardous drinking shall be provided with brief behavioral counseling interventions to reduce harmful alcohol use and/or refer to mental health and/or alcohol use disorder services, as medically necessary. Members are eligible for at least three brief interventions sessions per year. These sessions may be combined in one or two visits or administered as three separate visits and may be provided on the same date of service as the screening or on subsequent days. More information regarding screening and behavioral counseling and intervention is available on the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website. For more information also see Policy 404-1313 - Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.

Enhanced Primary Care Pain Management Program

The Enhanced Primary Care Pain Management Program has been developed to increase access to pain management services from Primary Care Providers for their linked Medi-Cal members. Such services are for the purpose of supporting primary care providers in offering Medication Assisted Treatment (MAT) for members on high doses of opioid medications for chronic non-cancer pain and with opioid use disorder or substance use disorder.

Eligible Members

Members eligible for the program include a provider's linked Medi-Cal members with an ICD-10 diagnosis of F11 through F11.99.

Eligible Providers

To be eligible to provide services under the program, rendering physicians must 1) be credentialed under a Primary Care Physician Services Agreement, and 2) have DEA X-licensure (DATA Waiver). In addition to meeting these requirements (credentialed and DEA X-licensure), rendering physician assistants and nurse practitioners must also be supervised by a physician that has DEA X-licensure.

Eligible Services

Eligible services under the program include initial and follow-up consultative evaluation and management services for the treatment of concerns related to opiate use, that meet the additional requirements described below.

Initial Visit

- History and physical exam;
- Assessment of cause of pain, current treatment regimen and any co-occurring substance abuse disorder;
- Development of a plan of care regarding MAT;
- Communications and follow-up with the Alliance regarding the Member's condition; and
- Must be billable under CPT codes 99204 or 99205

Follow-Up Visits

- MAT management;
- Services vary in duration and content depending on circumstances; and
- Must be billable under CPT codes 99212 through 99215

Services for each member entering the program must receive prior authorization from the Alliance, and otherwise be considered covered services under the provider's Primary Care Physician Services Agreement to be considered payable under the program. Authorization requests for services provided by physician assistants and nurse practitioners must be submitted under the provider's supervising physician, and billed under their supervising physician as well. Authorization under the program will not exceed one year in duration. Services rendered after the one-year expiration date will require a new authorization to remain in the program. There is no limit to the number of sequential authorizations requested.

To receive reimbursement for program services, the provider must include the authorization number on the claim form.

Compensation

Eligible program services provided by program eligible providers to program eligible members as described above are not considered Primary Care Physician Services subject to case management and will be paid fee-for-service rates by the Alliance as set forth in the Primary Care Physician Services Agreement as applicable. For more information, please see Policy 404-1731 - Medication Assisted Treatment.

Seniors and Persons with Disabilities

DHCS has requirements for providers treating the Seniors and Persons with Disabilities (SPD) population. These requirements are part of the Medi-Cal 2020 Waiver.

Health Risk Assessments

All newly-enrolled Medi-Cal only SPD members (excluding those who are dually-eligible for Medicare and Medi-Cal and those with other health care coverage) will receive a Health Risk Assessment (HRA) within 44 days of enrollment with the plan. The Alliance will administer the HRA either telephonically or by mail. All HRAs will be conducted in the member's preferred language. Members will be stratified into high- and low-risk, with high-risk members being offered Alliance Care Management Services for complex case management. Administering the HRA and coordinating follow-up care is not the responsibility of the PCP, but you will be notified regarding which members are receiving Alliance case management services. The HRA does not take the place of the Initial Health Assessment (IHA). The IHA is required for all new members and must be conducted within 120 days after the member's enrollment with the Alliance.

Specialists as PCPs

Specialists are eligible to act as PCPs for SPD members and members who are eligible for CCS. Members are linked to the provider's panel. To become an SPD or CCS PCP, providers need to meet the needs of the member within the scope of their practice, have a contract, and be credentialed. Provider offices will also have to undergo and pass a Facility Site Review as part of the credentialing process.

Sensitivity Training

All providers must receive sensitivity training to better meet the needs of the SPD population. In addition to periodic workshops, sensitivity training materials may be found on the Alliance provider website.

Physical Accessibility Review

All PCPs, high volume specialists, and ancillary providers will be surveyed for physical accessibility. The Physical Accessibility Review (PAR) is an informational survey that will evaluate accessibility in the following categories: parking, building exterior, building interior, restroom, exam room and medical equipment (height adjustable exam tables, patient accessible weight scales, equipment used for diagnosis and treatment). Results of the survey will be made available to providers and are published in the Provider Directory. Your practice site will be listed as either having Basic Access or Limited Access. The first PAR will take place as part of the initial credentialing process, or as soon as practical for existing PCPs and identified high volume specialists. Subsequent PARs will occur every three years, unless significant physical changes are made to the provider site. For more information about the PAR, please visit the Alliance website, as well as see Policy 401-1521 - Physical Accessibility Site Review.

For additional information regarding SPDs, see Policy 405-1112 - Care Management of Seniors and Persons with Disabilities for Medi-Cal.

For additional information regarding complex case management, see Policy 405-1113 - Care Management Complex Case Management.

Comprehensive Tobacco Cessation Services

PCPs are responsible for screening for smoking and tobacco use for all patients (of any age), providing counseling, and making appropriate referrals. Smoking and tobacco use counseling must be provided by a physician or other qualified health professional face-to-face. Supporting documentation is required for any

office audit for codes 99406 (smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes). Please note: 99407 is not to be billed in conjunction with 99406. Documentation must include the total time spent with the patient and what was discussed, including cessation techniques, resources offered, and follow-up. Counseling lasting less than three minutes is considered part of an Evaluation and Management (E&M) service (e.g. 99201-99215), not paid separately and not covered by 99406 and 99407. For additional information about this benefit and the Alliance Tobacco Cessation Support Program (TCSP), please see Policy 405-2217 - Comprehensive Tobacco Cessation Services or refer to Section 13: Health Education and Disease Management Programs.

Utilization Management Program

PCPs are accountable for aspects of the Alliance Utilization Management program within their scope of practice. For information on the program, please see Policy 404-1101- Utilization Management Program.

Case Management

Primary Care Physician Services

The services listed below are the Primary Care Physician Services to be provided by PCPs in accordance with the Case Management of a linked member. Providers shall administer these Primary Care Physician Services as medically necessary, unless this service is outside the scope of the medical services rendered by the provider. If the provider is paid on a capitation basis for Primary Care Physician Services, and an on-call or covering PCP sees a member linked to another provider, the Alliance will not pay the on-call or covering provider in addition to the capitation payment for the services listed below.

CPT CODE	DESCRIPTION
Office Visit	***New Patient***
99201	Problem focus history; 10 minutes
99202	Expanded problem focus; 20 minutes
99203	Detailed history, low complexity; 30 minutes
99204	Comprehensive history and exam; moderate complexity; 45 minutes
99205	Comprehensive history and exam; high complexity; 60 minutes
Office Visit	**Established Patient**
99211	Minimal problem; physician supervised services; 5 minutes
99212	Problem focus history and exam; 10 minutes
99213	Expanded problem focus history and exam; 15 minutes
99214	Detailed history and exam, moderate complexity; 25 minutes
99215	Comprehensive history and exam; high complexity; 40 minutes

Prevention	New Patient
99381	New patient, infant evaluation
99382	Early childhood, age 1 to 4 years old
99383	Late childhood, age 5 to 11 years old
99384	Adolescent, age 12 to 17 years old
99385	18 to 39 years
99386	40 to 64 years
99387	65 years and older

Prevention	Established Patient
99391	Established patient, infant, periodic reevaluation
99392	Early childhood, age 1 to 4 years old
99393	Late childhood, age 5 to 11 years old
99394	Adolescent, age 12 to 17 years old
99395	18 to 39 years
99396	40 to 64 years
99397	65 years and older

Other Evaluation and Management

99354	Prolonged Physician Service; Office or Outpatient setting; first hour
99355	Prolonged Physician Service; Office or Outpatient setting; each additional 30 minutes

Emergency Room

99281	ER Level 1
99282	ER Level 2
99283	ER Level 3
99284	ER Level 4
99285	ER Level 5

Minor Surgical Procedures

11900	Injection; intralesional up to 7 lesions
11901	More than 7 lesions
16000	Initial treatment for 1st degree burns
16020	Dressing and/or debridement of burns; small
16025	Dressing and/or debridement of burns; medium

16030	Dressing and/or debridement of burns; large
46600	Diagnostic Anoscopy
51701	Insertion of non-indwelling bladder catheter (e.g., straight catheterization for residual urine)
51703	Insertion of temporary indwelling bladder catheter, complicated (e.g., altered anatomy, fractured catheter/balloon)
54055	Electrodesiccation
69200	Clear outer ear canal
69210	Removal impacted cerumen

Injections

20550	Injection; single tendon sheath or ligament
20610	Arthrocentesis, aspiration or injection, major joint or bursa only

Collection/Handling Blood

36400	Venipuncture, age 3 or under
36405	Scalp vein
36410	Venipuncture, over age 3
36420	Venipuncture, under age 1
36425	Age 1 and over
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory

Vision and Hearing

92081	Visual field exam
92551	Screening test, pure tone
92552	Pure tone audiometry
92553	Air and bone
92555	Speech audiometry
92556	Threshold and discrimination
92557	Basic comprehensive audiometry
92567	Tympanometry (impedance testing)

Allergy Immunotherapy

95115	Single injection
95117	Multiple use allergy injections

95199	Unlisted allergy immunology services

ECG, Other Miscellaneous Test, Supplies

93000	Electrocardiogram
93005	Tracing only, without interpretation or report
93010	Interpretation and report only
93040	Rhythm ECG with report
93041	Rhythm ECG, tracing
93042	Rhythm ECG, report
94150	Vital capacity
94640	Inhalation treatment
95017	Allergy testing, with venoms
95018	Allergy testing, with drugs or biological
95052	Photo patch tests
95070	Bronchial allergy tests
97799	Unlisted physical medicine
99070	Special supplies

Notes

California Children Services (CCS) program services provided by CCS approved physicians, for the treatment of an Alliance Medi-Cal member's CCS eligible condition, are not considered Primary Care Physician Services subject to case management. These services will be paid fee-for-service rates by the Alliance as set forth in the Primary Care Physician Services Agreement, as applicable, subject to authorization requirements.

Children's Health and Disability Prevention (CHDP) services provided by CHDP enrolled providers to Medi-Cal members are not considered Primary Care Physician Services subject to Case Management. Providers shall bill the Alliance separately for these services and will be paid fee-for-service rates as set forth in the Primary Care Physician Services Agreement, as applicable, subject to any referral and authorization requirements.

Comprehensive Perinatal Services Program (CPSP) services provided to Medi-Cal members are not considered Primary Care Physician Services subject to Case Management and will be paid fee-for-service rates by Plan as set forth in the Primary Care Physician Services Agreement, as applicable, subject to any authorization requirements.

Enhanced Primary Care Pain Management Program services provided to members eligible under the program, by providers who are eligible to participate in the program are not considered Primary Care Physician Services subject to Case Management. These services will be paid fee-for-service rates by the Alliance as set forth in the Primary Care Physician Services Agreement as applicable, subject to authorization requirements.

Palliative Care services provided to Medi-Cal members are not considered Case Managed Primary Care Physician Services and will be paid fee-for-service rates by Plan as set forth in the Primary Care Physician Services Agreement, as applicable, subject to any authorization requirements. Providers must include a U1 modifier in the first position for every code submitted for Palliative Care services on the claim.

For more information on physician case management responsibilities, please see Policy 404-1313 - Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.