Section 6
Alliance Covered Benefits and Services

Covered Benefits

Medi-Cal

To view a summary of benefits for Alliance Medi-Cal members, please visit the Alliance member website.

Alliance Care IHSS Benefits

All health care services under the Alliance Care IHSS plan must be obtained from a participating Alliance provider, and all benefits are subject to the guidelines and procedures of our Utilization Management Department. The benefit year for Alliance Care IHSS is July 1 to June 30. There is a $3,000 copayment maximum per member per benefit year. To view a summary of benefits and copayments for Alliance Care IHSS members, please visit the Alliance member website.

Covered Services

Community Based Adult Services (Formerly Adult Day Health Care)

The Fee-for-Service (FFS) Medi-Cal benefit known as Adult Day Health Care ended in California on March 31, 2012. On April 1, 2012, the California Department of Health Care Services (DHCS) created a new benefit called Community Based Adult Services (CBAS). Effective, July 1, 2012, CBAS transitioned from a FFS Medi-Cal benefit to a managed care benefit, effectively administered through the Alliance.

There are four licensed CBAS centers that represent the three counties serviced by the Alliance. The Alliance is contracted with all four, providing effective coverage in Santa Cruz, Monterey, and Merced counties.

Licensed CBAS centers offer the following services to qualifying members:

- Professional nursing services
- Nutrition
- Physical Therapy
- Occupational Therapy
- Speech and language pathology services
- Transportation to and from the CBAS center, if required.

To qualify for CBAS services, members must be over the age of 18 and meet one of the following criteria:

- Meet “Nursing Facility Level of Care A” (NF-A) or above and meet “ADHC Eligibility and Medical Necessity criteria”; or

- Have a moderate or severe cognitive impairment, including moderate to severe Alzheimer's Disease or other dementia comparable to, Stages 5,6, or 7 Alzheimer's disease and meet "ADHC Eligibility and Medical Necessity criteria"; or
- Have a developmental disability and meet "ADHC Eligibility and Medical Necessity criteria"; or
- Have a mild to moderate cognitive disability, including Alzheimer's or dementia (comparable to stage 4 Alzheimer's disease), and meet "ADHC Eligibility and Medical Necessity criteria", and demonstrates need for assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
- Have a chronic mental illness and/or a brain injury, and meet ADHC eligibility and medical necessity criteria and demonstrate need for assistance or supervision with either:
    - Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
    - One need from the above list and one of the following: money management, accessing resources, meal preparation, or transportation.

Referrals for CBAS services may be made by a physician, community service agency, hospital or health care provider, or a CBAS center.

Prior authorization through the Alliance is required to obtain CBAS services. A face-to-face assessment by an Alliance registered nurse will be done prior to an assessment being started at the CBAS center. The authorization process entails eligibility screening, a multidisciplinary assessment at the CBAS center, completion of an Individualized Plan of Care (IPC) by the CBAS center, and decision-making by the Alliance. If approved after the Alliance assessment, the members may receive CBAS services from one to five days per week, depending upon the member's acuity and unique needs. Reauthorization is required every six months by submitting an Authorization Request to the Utilization Management Department, along with any necessary medical documentation for review.

For more information on CBAS, please see Policy 405-1111 - Community Based Adult Services and Enhanced Case Management.

eConsult Program

The Alliance offers contracted primary care physicians (PCPs), Physician Assistants (PAs) and Nurse Practitioners (NPs) providing primary care access to specialist networks via eConsult services. eConsult utilizes a HIPAA secure web-based platform to enable communication between a provider and a specialist. eConsult typically presents a brief question regarding a patient's symptom management or diagnosis and may include medical records and images. Like email, communication occurs asynchronously, but includes follow up questions and clarifications.

Program Eligibility

PCPs that are contracted and linked to Alliance Medi-Cal members may participate in this program. In addition, PAs and NPs that meet these same requirements, and are supervised by a PCP who participates in the program, are eligible.

Requirements of Participating Providers

All participating providers must agree to vendors' terms of service and utilize eConsult services exclusively for Alliance primary Medi-Cal members without other health care coverage. Supervising PCPs will oversee all cases submitted by PAs or NPs.

Note that the PCP remains solely responsible for the diagnosis and treatment of his or her patients. If a PCP is unsure of the course of action following use of eConsult, they are still obligated to deliver the appropriate standard of care through the established referral process.

eConsult Providers

The Alliance contracts with vendors that offer eConsult services for PCPs. Interested PCPs should contact the vendors directly to determine which organization best meets their needs. The vendors will provide training on how to use their platform and consult with specialists.

Alliance approved eConsult providers and contact information is listed below:

AristaMD
www.aristamd.com

(858) 750-4777

Direct Dermatology
www.directderm.com
Eliana Gonzalez, Provider Relations
eliana.gonzalez@directderm.com
(916) 599-1140

To become a referring specialist, physicians can contact Alliance eConsult vendors directly.

Urgent Visit Access

Urgent Visit Access offers an alternative access site for an urgent visit if the member's PCP is not able to accommodate an acute visit.

Participating Urgent Visits Access Site Requirements

Many Alliance PCPs are open evenings and weekends. In order to participate as an Urgent Visit Access participating provider, PCPs would:

- Provide urgent visits to non-linked Alliance members and
- Be open an extended hour each weekday, beyond the typical Monday – Friday, 8 a.m. to 5 p.m. or
- Be open for a minimum of four (4) hours on the weekends

The Alliance may make exceptions to these criteria on a case-by-case basis.

Member Steps

If a member needs care after regular office hours, they can take the following steps:

1. Call their PCP and ask if an appointment is available.
2. Call the Nurse Advice Line (NAL) for an over-the-phone assessment and guidance of what to do next.
3. If the member's PCP is unable to accommodate an urgent visit or by the recommendation of the NAL, the member may seek care at a participating Urgent Visit Access site. No referral is required.

Documentation

Urgent Visit Access sites have been asked to fax information to the member's PCP with details of the visit. This may be an after-visit summary or a full clinic note (preferred).

Referrals

Referrals required subsequent to the urgent visit will be directed to the PCP. If an urgent specialist referral is needed, a call should be made from the participating urgent visit site to the PCP to facilitate an immediate referral.

For more information on how to become a participating Urgent Visit Access site, please contact your Provider Relations Representative at: (800) 700-3874, ext. 5504.

Emergency Services

Emergency services are covered inpatient and outpatient services that are necessary to enable stabilization or evaluation of an emergency medical condition and are provided by a health care professional qualified to furnish emergency services.

An emergency medical condition is a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Serious jeopardy to the health of the individual or, in case of a pregnant woman, the health of the woman or her unborn child.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

No prior authorization is required for emergency/urgent services and emergency hospital admissions. All inpatient hospital stays require an authorization after admission. Authorization can be obtained by faxing a Hospital Admission Face Sheet and clinical documentation to the Utilization Management Department to (831) 430-5850.

For emergency hospital admissions and emergency room outpatient services, the hospital should verify the member's eligibility and assigned PCP by telephoning our Eligibility Verification System or Eligibility Clerk. Contracting facilities are obligated to notify the Alliance within one business day of service and to forward a copy of the ED report/face sheet to the PCP within the same timeframe.

When a member presents an emergency condition at a hospital or other provider facility and is admitted for inpatient services, the hospital/treating physician should notify the PCP and the Alliance within one working day of admission.

For more information on hospital services, see section below.

Providers may direct their Alliance Medi-Cal patients to any outpatient clinical laboratory that services Alliance Medi-Cal members. Alliance Care IHSS members should be directed to any contracted outpatient clinical laboratory. An updated list of contracted laboratories is available in the Provider Directory.

Hospital Services

NICU Services for CCS-Eligible Members

The Alliance will authorize CCS-eligible NICU stays based on the CCS policy for Medical Eligibility for Care in a CCS Approved Neonatal Intensive Care Unit. Authorization will only be provided for the level of services for which a NICU has been approved by DHCS. If the NICU is not CCS-approved, or if the level of care that is required by the member is above the NICU level of approval, the hospital must follow CCS guidelines for Stabilization, Transfer and Transport of a CCS-Eligible NICU Patient.

Medical Records

Each hospital is responsible for maintaining adequate medical records of patient care. Records should be maintained in accordance with applicable state and federal privacy laws. The Alliance has the right to review records for claims authorization and service authorization. All medical records should be maintained in a manner consistent with professional practices and prevailing community standards as well as all federal, state and accrediting body regulations. For more information, see Policy 401-1510 - Medical Record Review and Requirements.

Discharge Planning

Discharge planning is initiated upon admission to facilitate the transition of beneficiaries to the next phase of care. The discharge planning team is multi-disciplinary and consists of treating physician and hospital discharge planners. Physician responsibility includes participation in coordinating member discharge planning and referrals to appropriate post-discharge settings. Alliance staff will work with the hospital's discharge planning staff, as needed, in determining the most appropriate post-discharge setting.

Acute Administrative Days – Medi-Cal Only

Acute administrative days are those days approved in an acute care inpatient facility which provides a higher level of medical care than that currently needed by the patient. These days may be authorized for patients awaiting placement in skilled nursing facilities (SNFs) or intermediate care facilities (ICFs). For more information on how hospitals may qualify for reimbursement of acute administrative days, please see Policy 404-1520 - Administrative Day Criteria.

Identification and Referral of CCS Cases

Admitting physicians, hospital discharge planners, neonatologists, hospital pediatricians and other hospital staff, as appropriate, shall work with the Alliance to ensure that children with potentially CCS-eligible conditions are identified and referred to the local county CCS program for CCS eligibility determination. For more information on CCS referral procedures, please see Policy 404-1305 - Screening and Referral of Medically Eligible Children to CCS Program. Please refer to California Department of Health Care Services (DHCS) website for more information regarding California Children's Services (CCS).

Authorizations

For more detailed information about the hospital authorization process, please see the policies linked below:

Policy 404-1102 – Inpatient Review

Policy 404-1201 – Authorization Request Process

Policy 404-1521 - Hospital Stays Where Discharge, Death or Transfer Occurs on the Day of Admission

Policy 404-1524 - Long Term Care for Medi-Cal Members

Policy 404-1525 - Skilled_Nursing_Facility_Program_Policy_For_Medi-Cal

Utilization Management

For detailed information on the Alliance Utilization Management Program, please see Policy 404-1101 - Utilization Management Program.

Credit Balance Report

The Alliance requires all participating contracted Hospital Providers to complete a Credit Balance Report on a quarterly basis. The report is used to monitor, identify, and recover "credit balances" owed to the Alliance for improper or excess payments made to the provider resulting from claims processing errors. For detailed information on completing and submitting the Credit Balance Report, please see Policy 702-1300 – Credit Balance Report.

Laboratory Services

The Alliance reimburses contracted physicians for certain Clinical Laboratory Improvement Amendments.

(CLIA) waived lab tests that are performed in a physician's office, if the physician meets the requirements of 42 USC Section 263a (CLIA) and provides the Alliance with a current CLIA Certificate of Waiver. Effective in 2015, the Alliance has expanded the list of approved CLIA waived labs to include those allowed by Medi-Cal. More information on the codes can be found in the Pathology: Billing and Modifiers section of the Medi-Cal Provider Manuals. If a code is not located in the table below, providers should review the Medi-Cal Provider Manuals to confirm the code is allowed by Medi-Cal as a CLIA waived lab.

CLIA Waived Lab Tests*	
80048	Basic metabolic panel (calcium, total)
80053	Comprehensive metabolic panel
81003	Urinalysis by dipstick; automated w/o microscopy
82565	Creatinine; blood
83036	Hemoglobin; glycosylated (A1c)
83655	Lead
84443	Thyroid stimulating hormone (TSH)

*TB testing is Alliance approved, but is not a CLIA waived lab. Please use CPT code 86580 – Skin test; Tuberculosis, Intradermal New Technology Assessment

Upon request for information, following Policy 404-1714 - Technology Assessment, the Alliance will evaluate new technologies such as medical and behavioral health procedures, pharmaceuticals and devices, and will evaluate changes in the application of existing technologies to determine whether a new technology should be an added benefit.

Skilled Nursing Facilities and, Long Term Care, and Private Duty Nursing Medi-Cal

Long Term Care (LTC) is defined as care in a facility for longer than one full month. LTC facilities may include a Skilled Nursing Facility (SNF), sub-acute facilities (pediatric and adult) or intermediate care facilities.

Determination of the most appropriate level of care for the member, and the best facility to provide such care, is made by collaborative efforts between the PCP, the hospital Discharge Planning/Care Management departments, and the Alliance Utilization Management and Complex Case Management teams. Prior authorization is required for approval of admission to a long term care facility of any kind.

The criteria for receiving skilled-nursing services must meet the level-of-care standards set by Medi-Cal (Title 22, Section 51215).

- The patient must require the continuous availability of procedures, including but not limited to:Administration of IV, IM or SC injections and IV or SC infusions.
- Gastric tube or gastronomy feedings.
- Nasopharyngeal aspiration.
- Insertion or replacement of catheters.
- Application of dressings involving prescribed medications and aseptic techniques.
- Treatments that require observation by licensed health care staff to evaluate the patient's progress.
- Administration of medical gases under a prescribed therapeutic regimen.
- Restorative nursing procedures that require the presence of a licensed nurse.Medically necessary long term care will be authorized by the Alliance at the time of admission for members who meet the criteria. If the member does not meet the criteria for long term care, if no AR was submitted, or if the facility is unable to meet the member's nursing needs, a denial notice will be sent to the member, the PCP and the admitting physician. The notification will include the process to appeal the denial decision.

Unless otherwise determined, the PCP and member relationship continues during the limited long term care stay.

For more information on LTC and SNF benefits for Alliance Medi-Cal members, please see policies:
404-1524 - Long Term Care for Medi-Cal Members.

404-1525 - Skilled Nursing Program Policy for Medi-Cal

Medi-Cal Long Term Care Facility Admission and Discharge Notification (MC171) Form

Medi-Cal LTC Facilities are required to complete the Medi-Cal Long Term Care Facility Admission and Discharge Notification Form (MC171) on the day of admission or discharge of the patient. The MC171 form is located on the DHCS website.

On admission to an LTC facility, a Medi-Cal recipient or the recipient's representative must complete the

Medi-Cal Long Term Care Facility Admission and Discharge Notification (MC171) form, Parts I and II.

When a Supplemental Security Income (SSI) recipient enters a LTC facility, providers must notify a Social Security Administration (SSA) field office of the recipient's name, Social Security Number (SSN) and date of entry. SSI recipients are required to report their status to the provider when entering a nursing facility.

- The LTC facility must retain a copy of the MC171 form for its files and send either the original or a copy to the proper government agencies depending on whether:The patient receives Supplemental Security Income/State Supplemental Payment (SSI/SSP);

  or

- The patient receives aid under any program other than SSI/SSP.
- If the patient receives SSI/SSP, the original MC171 should be sent to the local Social Security
- Office. The aid code for these recipients is 10, 20, or 60. A copy of the MC 171 should also be forwarded to the local county welfare department.
- If the patient receives aid under a program other than SSI/SSP; the original MC171 should be sent to the local county welfare department. The aid code for these recipients will be other than 10, 20, or 60.
- The LTC facility is not required to submit a copy of the MC171 form to the California Department of Health Care Services, Medi-Cal Eligibility Division. The Medi-Cal field office will use the recipient's initial Treatment Authorization Request (TAR) as notification of the patient's admission.
- When the patient is discharged (or expires), the facility must complete Part III of the MC171 form and submit the original copy to the county welfare department.For additional information, please see the *Long Term Care (LTC) Manual*, Section: *Admissions and Discharges* of the Medi-Cal Provider Manuals.

Private Duty Nursing is an EPSDT supplemental services benefit (for individuals under age 21). For additional information, please see Policy 404-1720 Private Duty Nursing EPSDT Benefit.

Alliance Care IHSS

For Alliance Care IHSS members, prior authorization is required for approval of admission to a SNF of any kind. Determination of the most appropriate level of care for the member, and the best facility to provide such care, is made by collaborative efforts between the PCP, the hospital Discharge Planning/Care Management departments, and the Alliance Utilization Management and Case Management teams.

To qualify for skilled-nursing care, the patient must require the continuous availability of procedures, including but not limited to:

- Administration of IV, IM or SC injections and IV or SC infusions.
- Gastric tube or gastronomy feedings.
- Nasopharyngeal aspiration.
- Insertion or replacement of catheters.
- Application of dressings involving prescribed medications and aseptic techniques.
- Treatments that require observation by licensed health care staff to evaluate the patient's progress.
- Administration of medical gases under a prescribed therapeutic regimen.
- Restorative nursing procedures that require the presence of a licensed nurse.

Medically necessary skilled-nursing care will be authorized by the Alliance at the time of admission for members who meet the criteria. If the member does not meet the criteria for a SNF, if no AR was submitted or if the SNF is unable to meet the member's skilled nursing needs, a denial notice will be sent to the member, the PCP and the admitting physician. The notification will include the process to appeal the denial decision.

Telehealth

Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. (Section 2290.5(a)(6) of the Business and Professions Code).

Telehealth Coverage

In keeping with current California law (AB 415 passed in 2011), the Alliance provides coverage for telehealth services, as defined above. This service is intended specifically to provide access to specialty services that would otherwise have limited availability. Services may be delivered as asynchronous store and forward or synchronous interaction.

Synchronous Telehealth Services and Settings

Synchronous telehealth is real-time interaction between a member and a health care provider located at a distant site. The member's provider may be present at the originating site during synchronous interaction if deemed necessary. Synchronous telehealth services can be provided to Alliance members by any Alliance credentialed health care provider with the member's verbal consent, as documented in the patient's medical record.

Asynchronous Telehealth Services and Settings

Asynchronous telehealth is the transmission of a member's medical information, including photographs, x-rays, or other forms of data, from an originating site to the health care provider at a distant site without the presence of the member. Asynchronous store and forward telehealth services provides for the review of medical information at a later time by a physician or optometrist at a distant site without the patient being present in real time. The following health care providers may provide store and forward services:

- Ophthalmologists.
- Dermatologists.
- Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code).

The Alliance will pay for services in teledermatology, teleoptometry and teleophthalmology, as long as they meet federal and state guidelines for medical necessity and are covered benefits according to the Alliance member's Evidence of Coverage (EOC). Services provided by telehealth may require a referral from the PCP. Providers should follow the procedures outlined in Policy 404-1303 – Referral Consultation Request Process.

Patients receiving teledermatology, teleophthalmology or teleoptometry services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the patient's notification of the results of the consultation.

Telehealth services are also available for mild to moderate mental health services. See section 7: Carved Out Services: Medi-Cal for more information.

Telehealth services can be provided in a number of settings: physician office, clinic, hospital, skilled nursing facility, or a member's home. These would each be considered originating sites. A licensed provider must be present if the provider fee for the visit is to be reimbursable. If a licensed provider is not present at the originating site, a site facility fee may be billed in lieu of the provider fee for the visit. In addition, transmission cost fees may be billed. For lines of business that require a copay for services, the payment will be collected at the time of the member's visit to the originating site.

At the distant site expert providers would serve as consultants or offer ongoing care for specific conditions. That provider may bill for an office or inpatient consultation as well as transmission cost fees. For those lines of business that require a copay for services, the payment will be waived for services provided at the distant site.

The health care provider at the originating site must inform the member that telehealth services will be used and obtain the member's verbal or written consent, which will be documented in the member's medical record. In situations when the asynchronous store and forward system is used, members must be notified of their right to have interactive communication with the distant specialist at the time of the consultation or within 30 days of the patient's notification of the results of the consultation. In all circumstances, providers will abide by HIPAA laws, including not disclosing a member's personal health information to any third party without written consent.

The audio-video telemedicine system used, must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT-code billed.

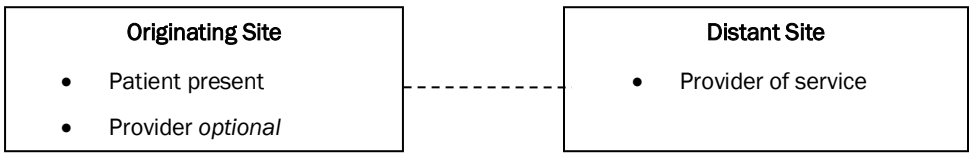
Billing Guidelines

Below are guidelines for providers using telehealth services to enable providers to accurately bill for such services. The Alliance will reimburse contracted providers for telehealth services as described in Alliance Policy 404-1727 – Provision of Telehealth Services.

Reimbursement for Telehealth Services

The three main models of telehealth services available to Alliance members are explained on the following pages.

Reimbursement for Traditional Synchronous Telehealth Services



Billing guidelines for originating site providers:

Originating Site	
Service	**Code**
Site facility fee	Q3014
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (*if present*)	E&M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.
Required Place of Service	Place of Service code "02" (not required for FQHC's, RHC's or HIS-MOA clinics)

If a licensed provider also is present at the telehealth originating site with the patient present and a progress note is generated by the originating provider, the visit is reimbursable. The scope of the interaction with the originating provider should be documented in the progress note that are distinct from those provided by the distant site and will be the basis of the E&M and other CPT code(s) billed. If an E&M code is included, the transmission cost fees may be billed. No modifier is needed at the originating site. For lines of business requiring a copay for services, the payment will be collected at the originating site.

Billing guidelines for distant site providers:

Distant Site	
Service	**Code**
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Initial hospital care or subsequent hospital care (new or established patient)	99221 – 99233
Licensed Provider Fee	99201 – 99215
Consultations: Office or other outpatient (initial or follow-up), Inpatient, and confirmatory	99241 – 99255
E-Consultations	99451
Required Modifier	95 modifier required for all CPT-Codes except Transmission Cost codes
Required Place of Service	Place of Service code "02" (not required for FQHC's, RHC's or HIS-MOA clinics)

For those lines of business that require a copay for services, the payment will be waived for services provided at the distant site.

Reimbursement for Asynchronous Telehealth Services (Store and Forward) for Teleophthamology, Teleoptometry and Teledermatology Services:

Originating Site Patient present Provider *optional*	Information stored and forwarded to Distant Site	**Distant Site** Provider of service

Billing guidelines for originating site providers:

Originating Site	
Service	**Code**
Site facility fee	Q3014
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (*if present*)	E&M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.
Required Place of Service	Place of Service code "02" (not required for FQHC's, RHC's or HIS-MOA clinics)

If a licensed provider also is present at the telehealth-originating site, with the patient present and a progress note generated by the originating provider, the visit is reimbursable as a visit. The scope of the interaction with the originating provider should be documented in the progress note, and will be the basis of the CPT code(s) used. If a CPT code is included, the originating site fee and the transmission cost fees may still be billed. No modifier is needed. For lines of business requiring a copay for services, the payment will be collected at the originating site.

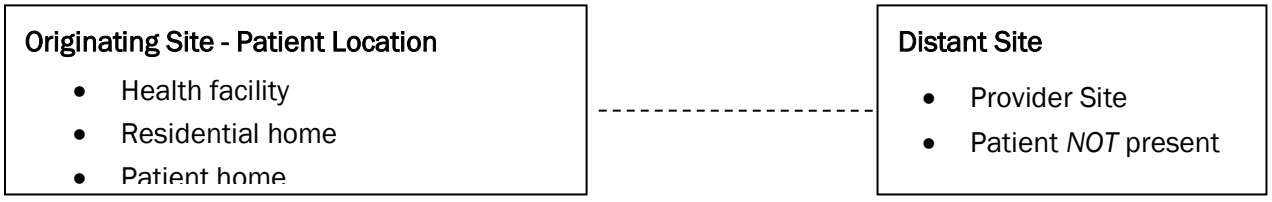
Billing guidelines for distant store and forward site providers:

Distant Store and Forward Site	
Service	**CPT Codes**
Licensed Provider Fee	92002, 92004, 92012, 92014, 99201-99215
Office consultation, new or established patient	99241 - 99255
E-Consultations	99451
Retinal photography with interpretation for services provided by optometrists or ophthalmologists	92250
Required Modifier	All asynchronous, store-and-forward services are billed with a "GQ" modifier
Required Place of Service	Place of Service code "02" (not required for FQHC's, RHC's or HIS-MOA clinics)

For lines of business that require a copay for services, the payment will be waived for services provided at the distant site.

Reimbursement for Synchronous: Provider to Patient Telehealth Services

The Telehealth Advancement Act of 2011 allows for telehealth services to be provided between a qualified provider and patient at a distant location. The location may be a health facility, residential home, patient's home or other location. For lines of business requiring a copay, the payment will be collected at the originating site.



Billing guidelines for the distant site:

Distant Site	
Service	**Code**
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (*if present*)	E&M codes 99201 – 99215
Required Modifier	95 modifier required for all CPT-Codes except Transmission Cost codes
Required Place of Service	Place of Service code "02" (not required for FQHC's, RHC's or HIS-MOA clinics)

For lines of business that require a copay for services, the payment will be waived for services provided at the distant site.

A licensed provider, who provides E&M services for a patient utilizing telehealth technology to access the provider's office, may submit claims for the service using the E&M code, without the modifier. The contracted arrangements for primary care providers and specialty providers continue to apply. T1014 Transmission Cost fee may also be billed.

Exclusions

Telehealth does not include email, telephone (voice only), text, inadequate resolution video or written communication between providers or between patients and providers.

Palliative Care Services

The Palliative Care benefit is designed to help members with advanced disease states to understand and receive supportive and specialized healthcare before hospice care is indicated. In its full capacity, the Palliative Care benefit will connect members with clinicians who are trained to focus on symptom management and who understand advance care planning and end of life complexities.

Eligible Members

Members eligible for the benefit are expected to have one (1) year or less life expectancy, be in the advanced stage of illness, have received appropriate patient-desired medical therapy, or for whom patient-desired medical therapy is no longer effective, and have started to access the hospital or emergency department as a means to manage late stage illness. Members should also have one or more of the following disease-specific eligibility criteria:

- Congestive heart failure (CHF): hospitalized due to CHF as primary diagnosis (no further invasive interventions planned) OR NYHA III or higher AND EF <30% or significant comorbidities
- Chronic obstructive pulmonary disease (COPD): FEV1<35% predicted and 24 hour and O_2 requirement less than 3L/min OR 24 hour O_2 requirement ≥3L/min
- Advanced cancer: any stage III or IV solid organ cancer, leukemia or lymphoma AND Karnofsky Performance Scale score ≤ 70 OR treatment failure of 2 lines of chemotherapy

- Liver disease: evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, AND ascites, spontaneous bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices OR evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.
- Other advanced disease states will be considered on a case-by-case basis

Eligible Providers

Contracted rendering physician leaders of Palliative Care teams must 1) be credentialed under Primary Care Physician Services Agreement or a Referral Physician Services Agreement, and 2) meet the Palliative Care specific requirements set forth in Policy 404-1527 – Palliative Care.

Eligible Services

Palliative Care services include advanced care planning, palliative assessment and consultation with a palliative care team, care coordination, and mental health and medical social services for counseling and support. Pastoral care may also be provided, though it is not reimbursed by the Alliance. Traditional Palliative Care provision includes curative and/or supportive treatment planning, pain and symptom management, medication side effects, emotional and social challenges, spiritual concerns, patient goal setting, and advance directives, including completion of physician order for life-sustaining treatment (POLST) form.

Palliative Care services must receive prior authorization from the Alliance. To receive reimbursement for Palliative Care services, the provider must include the authorization number on the claim form, as well as a U1 modifer as described below. Claims for Palliative Care services will be processed in accordance with Alliance policies and procedures. If Palliative Care services are provided to members with OHC or Medicare, the services rendered must be billed to the primary insurance first. The claim should be then sent to the Alliance with the primary insurer's explanation of benefits. All applicable coordination of benefit rules apply to claims for Palliative Care services.

The codes and frequency limits for Palliative Care services are listed below. Providers must include a U1 modifier in the first position for every code submitted for Palliative Care services on the claim.

Code	Description	Frequency Limitations
99202-99205	Office Or Other Outpatient Visit For The Evaluation And Management Of A New Patient	One time per 36 months per member
99212-99215	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient	One time per day per member
99241-99245	Office Consultation For A New Or Established Patient	One time per day per member
99304-99310	Initial Nursing Facility Care, Per Day, For The Evaluation And Management Of A Patient	One time per day per member

Code	Description	Frequency Limitations
99324-99328	Domiciliary Or Rest Home Visit For The Evaluation And Management Of A New Patient	One time per day per member
99334-99337	Domiciliary Or Rest Home Visit For The Evaluation And Management Of An Established Patient	One time per day per member
99341-99345	Home Visit For The Evaluation And Management Of A New Patient	One time per day per member
99347-99350	Home Visit For The Evaluation And Management Of An Established Patient	One time per day per member
99354	Prolonged Evaluation And Management Or Psychotherapy Service(s) (Beyond The Typical Service Time Of The Primary Procedure) In The Office Or Other Outpatient Setting Requiring Direct Patient Contact Beyond The Usual Service; First Hour	One time per day per member
99355	Prolonged Evaluation And Management Or Psychotherapy Service(s) (Beyond The Typical Service Time Of The Primary Procedure) In The Office Or Other Outpatient Setting Requiring Direct Patient Contact Beyond The Usual Service; Each Additional 30 Minutes	Four times per day per member
99356	Prolonged Service In The Inpatient Or Observation Setting, Requiring Unit/Floor Time Beyond The Usual Service; First Hour	One time per day per member
99357	Prolonged Service In The Inpatient Or Observation Setting, Requiring Unit/Floor Time Beyond The Usual Service; Each Additional 30 Minutes	Six times per day per member
99358-99359	Prolonged Evaluation And Management Service Before And/Or After Direct Patient Care; First Hour	One time per day per member
99487	Complex Chronic Care Management Services, With The Following Required Elements: Multiple (Two Or More) Chronic Conditions Expected To Last At Least 12 Months, Or Until The Death Of The Patient; Chronic Conditions Place The Patient At Significant Risk	One time per day per member

Code	Description	Frequency Limitations
99489	Complex Chronic Care Management Services, With The Following Required Elements: Multiple (Two Or More) Chronic Conditions Expected To Last At Least 12 Months, Or Until The Death Of The Patient; Chronic Conditions Place The Patient At Significant Risk	One time per day per member
99490	Chronic Care Management Services, At Least 20 Minutes Of Clinical Staff Time Directed By A Physician Or Other Qualified Health Care Professional, Per Calendar Month, With The Following Required Elements: Multiple (Two Or More) Chronic Conditions	No frequency limitation
99497	Advance Care Planning Including The Explanation And Discussion Of Advance Directives Such As Standard Forms (With Completion Of Such Forms, When Performed), By The Physician Or Other Qualified Health Care Professional; First 30 Minutes, Face-To-Face	One time per day up to two times per month per member
99498	Advance Care Planning Including The Explanation And Discussion Of Advance Directives Such As Standard Forms (With Completion Of Such Forms, When Performed), By The Physician Or Other Qualified Health Care Professional; Each Additional 30 Minutes	One time per day up to two times per month per member
G0505	Cognition And Functional Assessment Using Standardized Instruments With Development Of Recorded Care Plan For The Patient With Cognitive Impairment, History Obtained From Patient And/Or Caregiver, In Office Or Other Outpatient Setting Or Home Or Domi...	One time per three months per member
G0506	Comprehensive Assessment Of And Care Planning For Patients Requiring Chronic Care Management Services (List Separately In Addition To Primary Monthly Care Management Service)	One time per member at onset of chronic care management services

For the purpose of calculating frequency limitations, a *new patient* shall be defined as someone who has not been seen in the preceding three years by a practitioner or provider in the same specialty as the practitioner or provider who is rendering care.

For more information, please see Policy 404-1527 - Palliative Care.

Transportation: Emergency and Non-Emergency

Emergency Transportation from PCP Office to Hospital

On occasion members require admission to acute-care facilities directly from the PCP's office; in such cases we reimburse the costs of this transportation to the hospital.

When a PCP determines that a member requires immediate hospitalization from his or her office, the PCP may determine at his/her own medical discretion which is the most appropriate and safe mode of transportation.

If the PCP has determined that taxicab service is more appropriate than ambulance service, they must notify the Health Services Transportation & Linguistic Coordinator after the taxicab has been called to ensure reimbursement to the taxicab company. The Coordinator can be reached at (800) 700-3874 ext.5577. The Coordinator will document in the PCP's notification that a taxicab was called to transport the member to the hospital.

For more information about emergency transportation, please see Policy 404-1724 - Hospital Transportation from PCP Office.

Non-Emergency Medical Transportation: Medi-Cal

The Alliance covers Non-Emergency Medical Transportation (NEMT) as specified in the California Code of Regulations, Title 22, Section 51323. Such transportation is approved when the member has a medical condition that prevents them from traveling by another form of conveyance without jeopardizing the member's health.

NEMT will be authorized for the transfer of a member from a hospital to another hospital or facility provided that the transport is medically necessary, has been requested by an Alliance provider, and has been authorized in advance by the Alliance. We require advance notice of five days for all NEMT requests. Specifically, the following types of transport will be allowed:

- The member is being moved either to a higher or lower level of care. Please note that the transfer from one level of care to the same level of care at another facility will not be authorized if the requesting facility is able to meet the member's medical needs.
- The member requires transportation from his/her home to a medically necessary medical appointment for services covered by the Alliance.

The Alliance does not cover NEMT when a member is going from a facility to their home, unless the member is receiving hospice services.

The Alliance does not cover public transportation such as airplane, passenger car, taxicab or other forms of public conveyance. Selection of an appropriate transportation service will take the following into account:

- Member's medical and physical condition.
- Urgency of the need for transportation.
- Availability of transportation at the time of need.

If a member disputes a determination that they do not meet the criteria for coverage of NEMT, the Transportation Coordinator will review the transportation request for Non-Medical Transportation (NMT) criteria or for other options.

Please contact the Transportation Coordinator at 831-430-5577 or (800) 700-3874 ext.5577.

For more information on NEMT, please see Policy 404-1726 - Non-Emergency Medical Transportation.

Non-emergency Transportation: Alliance Care IHSS

Non-emergency transportation will be authorized for the transfer of Alliance Care IHSS members from a hospital to another hospital or facility provided that the transport is medically necessary.

Please contact the Transportation Coordinator at (800) 700-3874 ext.5577.

For more information on non-emergency transportation, please see Policy 404-1726 - Non-Emergency Medical Transportation.

Non-Medical Transportation: Medi-Cal Only

Non-Medical Transportation (NMT) services are available for Alliance Medi-Cal members. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members; this is currently available under the NEMT benefit.

NMT services are available for members currently using a wheelchair only if the member is able to ambulate without assistance from the driver. If assistance is required, the transportation would be arranged through NEMT. NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

Eligibility requirements:

- Members must be eligible at the time of service.
- Member must attest (in-person or over the phone) that all other transportation resources have been reasonably exhausted.
- Prior approval is required.
    - Transportation must be requested 5-7 business days in advance of the trip to ensure time to coordinate transportation.
- Transportation must be for an Alliance covered service or Medi-Cal service that is not covered under the Central California Alliance Health Managed Care Plan contract. This includes doctor's appointments, pharmacy, or to pick up medical equipment or supplies.
- The transportation provided must be the least costly method of transportation that meets the member's needs.

NMT transportation may be by public transportation, passenger car, taxicab, or any other form of public or private conveyance. The type of transportation authorized to members will depend on their circumstances and the lowest cost type of transportation available.

Mileage reimbursement will be based on IRS Standard mileage rate for Medical Purposes.

- The driver must be compliant with all California driving requirements.

- The driver cannot be the member.
- Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and the member must complete the MCP transportation attestation..

NMT services help must be requested **at least 5-7 business days in advance** for initial services or routine visits. More time may be necessary for more complex requests. Transportation requests should be directed to Transportation Services at 1-800-700-3874 ext. 5577.

For more information on Non-Medical Transportation, please see Policy 200-2010 – Non-Medical Transportation

For more information on the Meals, Transportation, and Lodging benefit for CCS-eligible members, please see Policy 405-3104 - Meals and Lodging ("Maintenance") for Members with CCS Eligibility.