Referrals

Members must obtain a referral from their PCP before scheduling an appointment with any other physician, except for a specialist to specialist referral for a CCS eligible condition or for the self-referral services described below under "Self-Referral." Authorization Requests must be submitted prior to provision of a service unless it is medically urgent or will result in an unnecessary extension of a hospital stay.

For authorization purposes, a requested service or medical equipment is approved if it is a covered benefit and is determined to be medically necessary. For more information on Medical Necessity see Policy 404-1112 - Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests.

Referral Requests for members under 21 years of age will be reviewed for potential CCS medical eligibility. For more information, please see Policy 404-1305 – Screening and Referral of Medically Eligible Children to California Children's Services (CCS) Program.

Referral Consultation Requests

PCPs should submit a Referral Consultation Request (RCR) when referring members for specialty physical health care to a provider within the Alliance's service area. PCPs should use an Authorized Referral form when referring members for specialty care to a provider *outside* of the Alliance's service area, or when referring Medi-Cal members for specialty care related to treatment of a CCS-eligible condition.

Referrals are not required from PCPs in the following four situations:

1. Emergency care
2. Direct specialist to specialist referrals (require Authorized Referral completed by the referring specialist and **submitted via fax** to the Alliance)
3. Direct specialist to occupational and physical therapy referrals (require RCR from the referring specialist).

For WCM CCS-eligible members, an authorization is required for all Specialist referrals. As with Authorized Referrals, referrals are not required for administrative members. PCPs are required to maintain a referral tracking system for members sent to specialists for care, and must follow up within a reasonable time frame to ensure that the member kept the appointment and obtain the specialist's report and recommendations.

Referrals are not required for members seen in the Emergency Department (ED) to the following specialists for the referenced treatments:

1. Orthopedic surgeons: for documented or suspected fracture, sprains, and strains

2. General surgeons: For chronic cholecystitis
3. Ophthalmologists: For emergency retinal detachment; corneal abrasions; burns and retained foreign bodies; acute ocular infections; and glaucoma emergencies
4. Pain management: For acute or acute on chronic lumbar and/or cervical radiculopathy

   For more information, please see Policy 404-1303 – Referral Consultation Request Process.

Referrals can be submitted online, by mail or by fax. When submitting via mail or fax, please be sure to date and sign the referral. You may submit referrals:

Online by logging into your Alliance Provider Portal account.

By fax to (831) 430-5515.

By mail to: Central California Alliance for Health
P.O. Box 660015
Scotts Valley, CA 95067-0015

View a sample of the Referral Consultation Request form, or instructions to complete the referral.

Some common examples of situations in which a referral is required include:

- Laboratory and diagnostic testing (non-routine, out-of-network).
- Specialty consultation/treatment.

Referral Guidelines

Specialists need the medical information on the referral to be as specific as possible. Care should be taken by the PCP in completing referrals since what is authorized will determine the scope and duration of services and claims paid for these services. You and/or other referring physicians are responsible for verifying the list of contracted providers for all referrals to ensure that the referral is being made to an appropriate Alliance network provider. CCS-eligible members must be referred to CCS-paneled specialists, when applicable. Referrals to non-contracted and/or out-of-network providers will be authorized under compelling medical circumstances and/or when medically necessary services are not readily available within the Alliance network.

The referral specialist is responsible to inform the PCP, of the patient's status and proposed interventions throughout the course of treatment. The PCP is responsible for maintaining the referral tracking system.

Unless otherwise specified, a standing referral will expire in 90 days; if indicated on the referral, however, the authorization may be valid for up to one year, after which a new referral is required.

All associated episodes of care for the listed items are covered with a referral override for that specialist, if the follow up care is for the original diagnosis code. For more information on the referral process, please see Policy 404-1303 - Referral Consultation Request Process.

Serious and Complex Medical Conditions

Providers should develop a written treatment plan for members with complex and serious medical conditions. The plan must provide for a standing referral or extended referral to a specialist, as appropriate. Regardless of the length of the standing referral, all specialist providers are required to send the PCP regular reports on the care and status of the patient.

The written treatment plan should indicate whether the patient will require:

- Continuing care from a specialist or specialty care center over a prolonged period of time.
- Standing referral visits to the specialists.
- Extended access to a specialist because of a life threatening, degenerative or disabling condition involving coordination of care by a specialty care practitioner (for extended specialty referrals, the requesting provider should indicate the specific health care services to be managed by the specialist vs. the requesting physician).

For additional information on extended referral authorization, please see Policy 404-1306 - Extended Referral Authorization.

Standing Referrals to an HIV/AIDS Specialist: Medi-Cal

Patients with HIV or AIDS are designated as administrative members and are deemed as having "a condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative, or disabling" — thus assuring that the member has a standing referral to a specialty HIV/AIDS provider.

To qualify as an HIV/AIDS Specialist, a provider must have a valid license to practice medicine in the state of California and meet *at least one* of the following criteria:

- Credentialed as an HIV Specialist by the American Academy of HIV Medicine.
- Board certified, or has earned a Certificate of Forms Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties; or
- Board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties; and
- In the immediately preceding 12 months, has clinically managed medical care to a minimum of 25 patients who are infected with HIV and has successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients; or
- In the immediately preceding 24 months, has clinically managed medical care to a minimum of 20 patients who are infected with HIV and has completed any one of the following:
- In the immediately preceding 12 months, has obtained Board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties;

- In the immediately preceding 12 months, has successfully completed a minimum of 30 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients; or
- In the immediately preceding 12 months, has successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients, and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

If properly certified a provider has the option, to be listed in the Provider Directory as an HIV/AIDS specialist. For more information on standing referrals to HIV Specialists, please see Policy 404-1312 - Standing Referrals to HIV/AIDS Specialists.

Audiology, Podiatry, Occupational and Speech Therapy and Incontinence Creams and Washes: Medi-Cal

Alliance provides coverage for Audiology, Podiatry and Speech Therapy services and for Incontinence Creams and Washes.

Audiology: A referral is required from the member's PCP.

Podiatry Services and Occupational and Speech Therapy: Alliance Medi-Cal members may have an initial visit (1 visit) with a podiatrist or speech or occupational health therapist without needing a referral from their PCP. The purpose of this visit would be to evaluate whether there is a need for treatment. Any additional visits or further treatment would require authorization from the Alliance. If the provider wishes to submit an authorization request for treatment, he/she would submit the results of the initial evaluation/consultation along with the authorization request.

Incontinence Creams and Washes: providers may continue to provide these supplies and submit claims for reimbursement following guidelines for authorization, threshold amounts and pricing.

Assistance with Referral Consultation Requests

View a sample of the Referral Consultation Request form, or Instructions to Complete the Referral. If you are unable to determine if a referral is required, please call our Service Authorization Coordinator at (800) 700-3874 ext.5506 (please have the CPT Procedure Code available to facilitate the research). You may also fax your completed Referral Consultation Request Form to (831) 430-5515.

Out-of-Service-Area Referrals

When a member needs specialty care or procedures, the member's PCP should refer the member, the majority of the time, to a contracted provider within the Alliance's service area.

If there is no contracted provider available within the service area, or the condition is complex, the PCP may refer the member to a non-contracted provider within the service area. The process for making these referrals is for the PCP to complete a Referral Consultation Request Form, sending one copy to the referral provider and one copy to the Alliance. The Alliance must review and approve referrals to out-of-service-area providers before the service can be provided. For in-service-area referrals, the Alliance copy is for review and

payment purposes only – the Alliance does not approve or deny in-service-area referrals. This helps to ensure that appropriate medical criteria are met and that the member is being referred to an appropriate provider. The process for these referrals is for the PCP to complete and submit an Authorization Request form to the Alliance.

Referrals to specialty care for members with a CCS-eligible condition—whether initiated by the PCP or another specialist, and whether being referred to an in-service-area or out-of-area provider —must be authorized by the Alliance. This is to ensure that CCS members are being directed to CCS paneled providers, as appropriate, when care is being provided for the CCS-eligible condition.

In general, the reasons for referring to a provider out of our service area are:

- The necessary procedure or service is not available through one of our in-service-area providers, or the condition is complex. The PCP may refer the member to a non-contracted provider within the service area by completing a Referral Consultation.
- The expertise required for consultation is beyond what is available through our in-service-area provider network.
- The member's medical needs are sufficiently complex to require service out of the area.

In the event of an urgent/emergent medical situation outside of the Alliance service area, the facility providing the service is required to contact us within one business day to confirm eligibility and service authorization.

All services requested will be reviewed for clinical appropriateness by an Alliance nurse, with final decisions made by the Chief Medical Officer or Medical Director.

For more information on out-of-service-area referrals, please see Policy 404-1310 - Authorization Process for Referrals to Out of Service Area and Non-Contracted Specialty Providers.

Self-Referral: No Authorization or Referral Required for Medi-Cal

Alliance Medi-Cal members may access certain services without a referral from a PCP, as long as the provider they choose is a member of the Alliance network and is within the Alliance's service area:

- Asthma education with an Alliance-approved asthma education provider.
- Diabetes education with an Alliance-approved prediabetes/diabetes education provider (except for CCS members, who will be directed to CCS paneled diabetes providers, as appropriate).
- Tobacco cessation support program..
- Other health education and disease management programs.
- Urgent Visit primary care services at Urgent Visit access sites.
- The limited allied health benefit allows members to self-refer for acupuncture, chiropractic, podiatry (note that some podiatric visits require authorization), speech and occupational therapy services. A maximum of two visits are allowed per month. Any additional visits or course of treatment will require an authorization with approval from the Alliance and the number of treatments allowed is based on the member's medical condition and current Alliance and Medi-Cal guidelines and benefits. For WCM

CCS-eligible members, an authorized referral is required for initial evaluation/consultation for Podiatry, Speech, and Occupational Therapy.

- Mental health services (except for psychological testing and BHT). For WCM CCS-eligible members, an authorized referral is required to ensure that the member is referred to a CCS paneled provider.
- Alliance Medi-Cal members also may self-refer to any willing Medi-Cal provider for family planning and sensitive services. Female Alliance members may self-refer to any willing Medi-Cal OB/GYN within the Alliance's service area for routine well woman care.
- Female Alliance Medi Cal members may self-refer to any willing medical OB/GYN for pregnancy services, or self-refer to a qualified certified nurse practitioner or certified nurse mid-wife, including use of alternative birth center facilities within California. NOTE: Home births are not a Medi-Cal covered benefit, and are not currently covered by the Alliance.

No prior authorization is required for emergency/urgent services and emergency hospital admissions. For emergency inpatient admissions or emergency services, the hospital should contact the Alliance for verification of the member's eligibility. 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. Contracting facilities are obligated to notify the Alliance within one day of admission to obtain authorizations, and confirm the length of stay and level of care needed by the patient.

Administrative members, i.e., those not linked to a PCP, may self-refer to a Medi-Cal provider within the Alliance's service area for covered benefits. In addition, authorization from the Alliance is not required for members with other health coverage including Medicare since the Alliance is not the primary payer.

No prior authorization is required for family planning and sensitive services. Family planning services include birth control and pregnancy testing and counseling. Sensitive services include pregnancy testing and counseling, birth control, AIDS/HIV testing, sexually transmitted infection (STI) testing and treatment and termination of pregnancy. These services are listed alphabetically below:

- Abortion/termination of pregnancy (legal, unspecified, failed).
- Contraception and contraceptive management, including provision of contraceptive pills/devices/supplies and tubal ligation and vasectomy.
- Diagnosis and treatment of STIs if medically indicated.
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Health education and counseling necessary to make informed choices and understand contraceptive methods.
- High-risk sexual behavior.
- Laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods.
- Limited history and physical examination.

- Observation following alleged rape or seduction.
- Phthirus pubis (pubic lice) and Pubic Scabies.
- Pregnancy exam or test, pregnancy unconfirmed.
- Rape examination.
- Screening, testing and counseling of at-risk individuals for HIV and other STIs and referral for treatment.

For more information about which services Medi-Cal members may access without a referral from a PCP, please see the following policies:

Policy 404-1309 - Member Access to Self-Referred Services

Policy 404-1702 - Pon of Family Planning Services to Members

Policy 404-1707 Acupuncture Services for Medi-Cal Members

Policy 404-1710 Pediatric Therapies for Medi-Cal Recipients

Policy 405-2110 Disease Management Programs

Prior Authorizations

Individual Authorization Requests (ARs) are reviewed by a Prior Authorization nurse or Pharmacist according to predetermined criteria, protocols and the medical information from the physician or other provider. In some cases, the nurse may need to contact the provider directly to request additional information or one of the Alliance Medical Directors or Pharmacists may need to speak directly with the provider to discuss the request.

Authorization Requests (AR) for members under 21 years of age will be reviewed for potential CCS medical eligibility. For more information, please see Policy 404-1305 – Screening and Referral of Medically Eligible Children to California Children's Services (CCS) Program.

Only licensed medical professionals employed by the Alliance make decisions about ARs. Only our Chief Medical Officer, Medical Directors or Pharmacists have the authority to modify or deny ARs. Authorization decisions are based upon evidence-based Alliance policies as well as nationally recognized standards including:

1. Title 22 criteria
2. Medi-Cal Medical Necessity Guidelines (when available)
3. California Children's Services (CCS) Medical Necessity Guidelines (when available)
4. Alliance Health Services & Pharmacy Guidelines and Policies & Procedures approved by the
5. Continuous Quality Improvement Committee and the Pharmacy and Therapeutics Committee.
6. Evidence-based guidelines, such as:
    - MCG (formerly Milliman Care Guidelines)
    - Medicare (CMS) Guidelines
    - Consensus statements and nationally recognized standards of practice.
7. Guidelines developed by other health plans.
8. Expert opinion:
    a. Clinical advisors serving on Alliance Committees
    b. Outside Independent Medical Review

For more information on Medical Necessity, see Policy 404-1112 - Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests.

For more information about timely submission of ARs, please see Policy 404-1201 - Authorization Request Process.

Medical Services Requiring Prior Authorization

Common medical services or procedures that generally require prior authorization include:

- Allergy treatment. (please see Policy 404-1734 – Immunotherapy Authorization).
- Genetic Testing (Please see Policy 404-1715 - Genetic Testing)
- Home Health services.
- MRIs and unlisted CT scans.
- Physical, occupational and speech therapy.
- Podiatric treatment.
- Outpatient surgery.
- Non-emergency hospitalizations, except for an obstetrical delivery.
- Medical supplies and Durable Medical Equipment (DME).
- Requests for referral to an out-of-service-area provider/facility or a non-contracted provider/facility.
- Non-Medical Transportation
- Palliative Care Outpatient Services
- Sleep studies (please see Policy 404-1711 — Sleep Study (Polysomnography/Sleep Disorder Testing) Authorizations)
- Sclerotherapy procedure (please see Policy 404-1203 — Surgical Treatment of Varicose Veins)
- Electromyography, Nerve Conduction Studies (please see Policy 404-1713 —Electromyography, Nerve Conduction Studies)
- Drugs or treatment interventions not included in our Formulary (or if the quantity requested is more than a 90-day supply for maintenance drugs and a 30-day supply for all other agents).
- Total Joint Replacement Surgery (Please see Policy 404-1733 – Total Joint Replacement)

Acupuncture Services – Medi-Cal

Prior authorization is required for more than two acupuncture treatments and is limited to 20 visits per authorization for treatment of pain. Note that members can self-refer for up to two visits per month. For more information, please see Policy 404-1707 Acupuncture Services for Medi-Cal Members

Acupuncture and Chiropractic Services - IHSS

Prior authorization is required for acupuncture and chiropractic care, which are limited to 20 visits per benefit year.

Laparoscopic Cholecystectomy and Laparoscopic Cholecystectomy with Cholangiogram

Elective, emergent, or urgent laparoscopic cholecystectomy, or laparoscopic cholecystectomy with cholangiogram, do not require prior authorization. If inpatient admission is required, the admitting facility must notify the Alliance of admission within one business day. Please see Policy 404-1204 —Laparoscopy – Cholecystectomy Authorization Process for more information.

Medical Supplies and DME

For more information about requests for Medical Supplies and DME, see Policy 404-1603 - Medical Supplies Authorizations or Policy 404-1601 - Durable Medical Equipment (DME) Authorization.

Physical Therapy

Authorization requests will be considered according to the criteria and procedures described in Policy 404-1706 - Physical Therapy. For coding information see Section 10. Claims for designated codes that allow flexibility in providing a variety of physical therapy modalities without having to request adjustments to the initially submitted AR as the treatment plan changes.

Behavioral Health Services Requiring Prior Authorization

Behavioral health services that require prior authorization include:

- Psychological and neuropsychological testing.
- Behavioral Health Treatment (BHT).

To request authorization for a psychological test or BHT for an Alliance Medi-Cal member contact Beacon Health Options via their toll-free number 24 hours a day, 365 days a year at (855) 765-9700.

Submitting Authorization Requests

Prescribing physicians may request authorization by completing an Authorization Request (AR) Form and submitting it via:

- The Alliance Provider Portal.
- Fax to (831) 430-5850.

- U.S. post to: Central California Alliance for Health, P.O. Box 660015, Scotts Valley, CA 95067-0012.

For questions regarding Authorization Requests, please call (831) 430-5506.

When a member requests a specific service, treatment, or referral to a specialist, it is the PCP's responsibility to assess the medical need before providing or referring for treatment. If the service requested is not medically indicated, discuss an alternative treatment plan with the member or his/her representative.

Adherence to the following checklist for effective submission of an Authorization Request will assure the timeliest decision:

- ✓ Please complete the form — an illegible handwritten form may be returned to the provider.
- ✓ Be sure to include your name, address and contact number — and fax number.
- ✓ Be sure to include member's name, address, age, sex, date of birth, and identifying information such as the member's Alliance ID Number.
- ✓ The Medi-Cal identification number must be correct. Refer to the Medi-Cal card if necessary.
- ✓ Enter into the appropriate box the description of the diagnosis and ICD-10 or CPT code with appropriate modifiers that most closely describe the member's condition.
- ✓ Use the correct nine-digit provider identification (NPI) number. If the patient is hospitalized, the hospital provider number must be used.
- ✓ Attach documentation that supports the medical necessity of the request to the form (in addition to providing documentation required in the Medical Justification box).
- ✓ Be sure to sign and date the form (must be signed by the referring provider).
- ✓ Submit a separate AR for each service request per member; the AR will be given a unique number that is used to facilitate reimbursement.

Routine Pre-Service Requests

The prescribing provider must complete an Authorization Request before the service is performed. For routine pre-service requests for procedures/services that can be pre-scheduled without danger of adverse outcome to the member, the Alliance will usually make a determination *within 5 business days, but no longer than 14 days* from receipt of the request and appropriate documentation of medical necessity.

In certain circumstances, a decision may be deferred for *an additional 14 days* when the member or provider requests an extension, or if the original AR did not contain sufficient information.

All decisions for Authorization Requests are communicated to the provider by fax *within one business day* of the decision; providers inform the member about the decision. Decisions to modify or deny Authorization Requests are communicated to the member in writing *within two business days* of the decision; a copy will be sent to the provider then an Authorization Request is concurrent with services being provided, the Alliance will ensure that medically necessary care is not interrupted or discontinued until the members treating physician has been notified of the decision and a care plan has been agreed upon by the treating provider/PCP that is appropriate for the medical needs of the patient.

Expedited/Urgent Requests

In medically urgent situations, you may request an expedited Authorization Request review by calling our Health Services Department at (800) 700-3874 ext.5506 or faxing it to (831) 430-5850. Expedited Authorization Requests will be reviewed within three business days or as soon as possible after receipt of the request when the provider indicates that following a standard timeframe could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function.

Post-Service Authorization Requests

If it was not possible for the provider to obtain authorization before providing a medically necessary service, we will respond to a post-service Authorization Request if it is received within 30 calendar days of initiation of the service; if received later, the retrospective Authorization Request may be denied for non-timely submission. Please note that a post-service AR must be accompanied by documentation explaining why the authorization was not requested earlier. Our response will inform the provider of the decision to approve, modify or deny the Authorization Request.

While elective surgery requires prior authorization, under exceptional medical circumstances we may provide authorization after the fact.

If an Authorization Request is submitted for a member who has obtained retroactive eligibility, it must be received by the Alliance within 60 calendar days of the date on which the member obtained eligibility or it will be denied for non-timely submission.

Following are conditions whereby an Authorization Request may be submitted for post-service consideration:

- Member's eligibility was delayed.
- When "other coverage" will not pay the claim.
- Wheelchair repairs exceeding $500.
- When the patient hides Medi-Cal eligibility.

For more information about the authorization review process, please see Policy 404-1201 - Authorization Request Process.

Authorization Requests for Ancillary Services

Prior authorization is required for ancillary services such as home health care, medical supplies, rehabilitation services and DME. Ancillary services requiring prior authorization include, but are not limited to, the following:

- Durable Medical Equipment (purchase or rental).
- Hearing devices.
- Physical/occupational therapy.
- Speech pathology and audiologic services.
- Home Health Agency services.

- Medical supplies.
- Non-emergency medical transportation services.

Hospital Inpatient Services

Admissions to an acute-care facility or Ambulatory Surgery Center for scheduled surgery require prior authorization. All requests must be accompanied by the appropriate medical documentation including, but not limited to:

- Laboratory test results.
- X-rays.
- Medical records.
- Other reports that have relevance to the planned admission (e.g., pre-operative history and physical).

Emergency and urgent admissions do not require prior authorization. However, the Alliance must be notified by the facility of emergency admissions within one business day.

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 the treating physician and hospital discharge planners. Physician responsibility includes participation in coordinating member discharge planning and referrals to appropriate pt-discharge settings. Alliance staff will work with the hospital's discharge planning staff, as needed, in determining the most appropriate post-discharge setting.

For more information about hospital services please see Section 6. Alliance Covered Benefits and Services.

Obtaining a Second Opinion

Members, members' parents, members' custodial parents, members' legal guardians, and other authorized representatives for the member may request a second opinion about a recommended procedure or service. The Alliance honors all requests for second opinions without the need for a prior authorization as long as the second provider is contracted with the Alliance and within the Alliance's service area.

All referrals for CCS-eligible members require a prior authorization, including referrals for second opinions.

Second opinions may be rendered only by an appropriately qualified health care professional to review and treat the medical condition in question. Referrals to non-contracting medical providers or facilities may be approved only when the requested services are not available within the Alliance network.

If the provider giving the second opinion recommends a treatment, diagnostic test, or service that is medically necessary and covered by the Alliance, the PCP must provide or arrange for the service.

For more information on obtaining a second opinion, please see Policy 404-1307 - Medical Second Opinions.

Status of Authorization Requests

Our Health Services Authorization Coordinators will review AR forms for completeness and will help you with any aspect of the process, including answering questions regarding the status of ARs (800) 700-3874 ext.5511.

Deferrals and Denials

As discussed earlier in this section, decisions about requests for authorization may be deferred or denied. The most common reasons for such decisions are outlined in the chart below.

When a request is denied, a Notice of Action letter will be mailed to the member no later than the second business day after the decision, with a copy sent to the provider. If the denial is a result of insufficient information from the provider, we will inform the member that the case will be reopened when complete information is received. The denial letter will explain the reason for denial of the request and will provide information about the member's right to appeal the decision.

If you need clarification of the reason your AR was denied, please call the Alliance's Authorization Coordinator at (800) 700-3874 ext.5506.

Notes on the Status of Authorization Requests

Status	Comments
Approved as Requested	You may provide service as requested. Please remember to include the AR# on your claim.
Approved as Modified	Most Common Reasons for Approved as Modified: • Fewer visits are authorized than were requested on the AR. • Number of inpatient days requested on the AR is not within the guidelines on length of stay for the requested procedure. • Dates of service requested on the AR do not match the dates that the member is Alliance eligible.
Extended / Deferred	Most Common Reasons for Extended / Deferred AR: • AR form incompletely filled out; often lacks Procedure (CPT) and/or diagnosis codes (ICD-10), and/or narrative information on the procedure and/or codes that are being requested. • Insufficient medical information supplied on or with the AR form to enable appropriate medical decision. • Necessary equipment pricing catalog pages not submitted.

Status	Comments
Denied	Common Reasons for a Denial: • Request is for dental care services, which are Medi-Cal services authorized and reimbursed by an agency *other than the Alliance*. • Request is for specialty mental health services, which are services, authorized and reimbursed by county Mental Health Plans. • Documentation insufficient to support the medical necessity for the requested procedure/equipment. • Request was not submitted in a timely fashion. A denial letter will be sent to the member, giving an explanation for the denial and information about rights to appeal the decision. If you need clarification of the reason your AR was denied, please call the Alliance's Authorization Coordinator at (800) 700-3874 ext.5506.

For more details, see Policy 404-1109 - Disclosure of Utilization Management Process to Providers, Members and the Public.

Self-Referrals (No Authorization or Referral Required): Alliance Care IHSS

Alliance Care IHSS members may access certain basic services without a referral from a PCP, as long as the provider they choose is a member of the Alliance network and is within the Alliance's service area:

- Asthma education.
- Diabetes Prevention and Self-Management education .
- Other health education & disease management programs.
- Alliance Care IHSS members may self-refer to any contracted provider within the Alliance's service area for family planning services, annual well woman services and pregnancy services.

For more information about self-referral, please see the following policies:

Policy 404-1309 - Member Access to Self-Referred Services

Policy 404-1702 - Provision of Family Planning Services to Members

Newborn examinations and nursery care are covered while the mother is hospitalized; newborns may also be eligible for care during the first 30 days if they do not qualify for Medi-Cal.

No prior authorization is required for emergency/urgent services and emergency hospital admissions. For emergency inpatient admissions or emergency services, the hospital should contact the Alliance for verification of the member's eligibility. All inpatient hospital stays require an authorization after admission. Authorization can be obtained by sending a Hospital Admission Face Sheet and clinical documentation to the UM Department. Contracting facilities are obligated to notify the Alliance within one day of admission to obtain authorizations and to confirm the length of stay and level of care needed by the patient.

For more information on hospital services, please see Section 6. Alliance Covered Benefits and Services.

The Alliance will provide an external, independent review process to examine decisions regarding (a) denial, delay or modification of service based upon medical necessity and (b) experimental or investigational therapies. For additional information about external independent medical reviews, see Policy 404-1113 - External Independent Medical Review. For more details refer to Policy 404-1109 - Disclosure of Utilization Management Process to Providers, Members and the Public.

Summary of Referral and Authorization Requirements for Medi-Cal

Referral Guidelines		
Service	**Linked members who are assigned to a Primary Care Physician.**	**Un-linked or administrative members who do not have a PCP assignment.**
Referral / specialty consultation (non – CCS) – **in-area**	Prior Approval and authorization are not required. PCP completes "**Referral / Consultation**" form and submits to the Alliance.	Member may self-refer. Provider must accept Medi-Cal and bill the Alliance.
Referral / specialty consultation (CCS) – **in-area**	**Prior authorization approval is required.** PCP or specialist complete "Authorization Request" form and submit to Alliance for review.	PCP or specialist complete "Authorization Request" form and submit to Alliance for review.
Referral / specialty consultation – **out-of-area**	**Prior authorization approval is required.** PCP or specialist complete "Authorization Request" form and submits to Alliance for review.	Member may self-refer. Provider must accept Medi-Cal and bill the Alliance.
Allergy Treatment	PCP completes the **Referral Consultation** form for an initial evaluation and submits the form to the Alliance. Additional treatment requires a prior authorization request with approval from the Alliance.	Member may self-refer for an initial evaluation. Provider must accept Medi-Cal and bill the Alliance. Additional treatment requires an authorization.
Physical therapy	The initial Physical Therapy evaluation and treatment requires a Referral Consultation Request form from a member's linked PCP, or treating physician, for claims payment. The Referral Consultation Request includes evaluation and treatment of up to 12 PT encounters. Additional treatment requires a prior authorization request with approval from the Alliance.	For those members who are Administrative Members, or non-PCP linked, a provider prescription is required for an initial evaluation and treatment.
Podiatry, Speech, Occupational Therapy	Members may self-refer for an initial evaluation. Treatment requires a prior authorization request with approval from the Alliance. The number of treatments is based upon current Alliance and Medi-Cal guidelines and benefits.	

Referral Guidelines		
Service	**Linked members who are assigned to a Primary Care Physician.**	**Un-linked or administrative members who do not have a PCP assignment.**
Chiropractic	Members can self-refer up to a maximum of 2 treatments per month combined with limited allied health services. Additional treatments require a prior authorization request with approval from the Alliance.	
Acupuncture	Members can self-refer up to a maximum of 2 treatments per month combined with limited allied health services. Additional treatments require a prior authorization request with approval from the Alliance.	
Family planning and sensitive services	Member can self-refer to any provider that is a Medi-Cal provider.	
OB care	Member can self-refer to any in-area Medi-Cal obstetrical provider.	
Authorization required for:		
DME, medical supplies, prosthetics and orthotics	Purchase: individual item over $250.00 Rental: over $100/month Repair or Maintenance: over $500 Incontinence supplies: over $165	
Hospital care	Any elective admission including surgical procedures All transplants	
Imaging procedures	MRI PET scans Unlisted ultrasound, nuclear medicine and CT	
Diagnostic procedure	Cardiac catheterizations BRCA and oncotype testing Small bowel video endoscopy PCTA	
Surgical or therapeutic procedures	Outpatient procedures done in a free standing surgery center or outpatient hospital Implants surgically placed in an Outpatient/Ambulatory Surgical Center which exceed in aggregate $2500.00 Office based procedures that could be cosmetic in nature Nutritional supplements and TPN Immune globulin greater than one injection Auditory therapy	
Home Health	Requires authorization. The Alliance will guarantee payment for the initial home health evaluation for members discharged from the hospital	

Referral Guidelines		
Service	**Linked members who are assigned to a Primary Care Physician.**	**Un-linked or administrative members who do not have a PCP assignment.**
Other	Hearing aids Non-emergency medical transportation – any medical transportation request requires prior authorization	