COMMUNITY HEALTH CENTER NETWORK

New Provider Orientation

CHCN New Provider Orientation Packet

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Welcome to Community Health Center Network (CHCN)!

CHCN is committed to excellent, affordable care for underserved communities of the East Bay. CHCN is a partnership of eight federally qualified health centers located in the East Bay of California. We support our member health centers with business operations related to Medi-Cal managed care so the health centers can focus on what matters most—patients. Members in the CHCN network receive access to all medically necessary benefits through CHCN's network of contracted providers.

Our member health centers formed CHCN in 1996 to participate more effectively in newly-launched state managed care programs. The formation of CHCN built upon 20 years of collaboration in health policy and advocacy work through CHCN's sister organization, the Alameda Health Consortium.

When I first started at LifeLong Medical Care in 1999, we wrote on paper charts, we had no behavioral health on-site and we had no data (actionable or otherwise) to support the health of our population. Fast forward to the present – most patients seen in our clinics have managed care and no longer do we use paper charts. CHCN has partnered to deliver integrated behavioral health, and we work with quality improvement staff in the clinics to produce actionable data. It is my honor to serve as Chief Medical Officer.

CHCN supports the following health centers:

- Asian Health Services
- Axis Community Health
- Bay Area Community Health
- La Clinica de La Raza
- LifeLong Medical Care
- Native American Health Center
- Tiburcio Vasquez Health Center
- West Oakland Health Council

For more information on CHCN policies and procedures, please refer to the CHCN Provider Operations Manual at https://connect.chcnetwork.org/Provider-Library. You may sign up for our community update e-newsletter to learn more about news, ideas, and people in the health center family of providers, staff and partners. Email providerservices@chcnetwork.org to subscribe.

Sincerely,

Dr. Laura M. Miller, M.D.
Chief Medical Officer

Visit and follow us at:
Website: https://chcnetwork.org/
Facebook: https://www.facebook.com/alamedahealthconsortium/
Twitter: https://twitter.com/ACHealthCenters

Attestation of Provider Training

By signing below, I attest that I have received materials and training on the following subjects as they relate to Community Health Center Network and its contracted health plan partners, Alameda Alliance for Health and Anthem Blue Cross.

- Access to Care Appointment Standards
- Care Neighborhood
- Cultural Humility
- Electronic Consult Program
- Fraud, Waste and Abuse
- Getting to the Heart
- Member Grievances
- Member Rights and Responsibilities
- Quality Management and HEDIS Measures
- Interpretive Services
- Transportation Services
- Utilization Management

Date: _____ **Signature**: _____

Provider Name: _____

Provider Group Name: _____

Practice Address: _____

City: _____ **State:** CA **Zip:** _____

Medi-Cal Non-Emergent Medical Appointment Access Standards

Service	Access Standard
Access to PCP or designee	24 hours a day, 7 days a week
Non-urgent Care appointments for Primary Care	Must offer the appointment within 10 business days of request
Adult physical exams and wellness checks with PCP	Must offer the appointment within 10 business days of request
Non-urgent appointments with Specialist physicians	Must offer the appointment within 15 business days of request
Urgent Care appointments that do not require prior authorization	Must offer the appointment within 48 hours of request
Urgent Care appointments that require prior authorization	Must offer appointment within 96 hours of request
First Prenatal Visit	Must offer the appointment within 5 business days of request
Child physical exam and wellness checks with PCP	Must offer the appointment within 10 business days of request
Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of request
Initial Health Assessment (members age 18 months and older)	Must be completed within 120 calendar days of enrollment
Initial Health Assessment (members age 18 months and younger)	Must be completed within 60 calendar days of enrollment

Member Rights and Responsibilities

CHCN members have these rights:

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including Covered Services.
- To be able to choose a primary care provider within the Contractor's network.
- To participate in decision making regarding your own health care, including the right to refuse treatment
- To voice grievances, either verbally or in writing, about the organization or the care received.
- To make recommendations about the member rights and responsibilities.
- To receive care coordination.
- To request an appeal of decisions to deny, defer, or limit services or benefits.
- To receive oral interpretation services for their language.
- To receive free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To disenroll upon request. Beneficiaries that can request expedited disenrollment include, but are not limited to, beneficiaries receiving services under the Foster Care, or Adoption Assistance Programs; and members with special health care needs.
- To access Minor Consent Services.
- To receive written member informing materials in alternative formats (including braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by the Contractor, providers or the State.

CHCN members have these responsibilities:

- Tell the CHCN and your doctors what we need to know (to the extent possible) so we can provide care.
- Follow care plans and advice for care that you have agreed to with your doctors.
- Learn about your health problems and help to set treatment goals that you agree with, to the degree possible.

- Work with your doctor.
- Always present your health plan Member ID Card when getting services.
- Ask questions about any medical condition and make certain you understand your doctor's explanations and instructions.
- Give your doctors and CHCN correct information.
- Help CHCN maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
- Make and keep medical appointments and inform your doctor at least 24 hours in advance when an appointment must be cancelled.
- Treat all CHCN staff and health care staff with respect and courtesy.
- To have access to, and where legally appropriate, receive copies of, amend or correct your Medical Record.
- Use the emergency room only in case of an emergency or as directed by your doctor.

Care Neighborhood
Clinic-Based Case Management for High-Risk Members

CHCN has developed and piloted an innovative case management program for high risk members. Care is delivered by embedded clinic-based community health workers (CHW), who are integrated into the medical home team. CHCN provides technical training and support, inpatient support and best practice training and tools. High risk members are connected to community resources to support needs around the social determinants.

Case Management System
CHCN developed a case management system for CHWs. The system integrates claims, EHR and community data to drive workflow and help CHWs manage their high risk panel.

Data Analytics
CHCN developed a predictive risk model to identify high risk patients. CHCN also provides monthly dashboards and is conducting an impact evaluation.

Technical Training and Support
Experienced LCSWs provide on-going training and consultative support for CHWs.

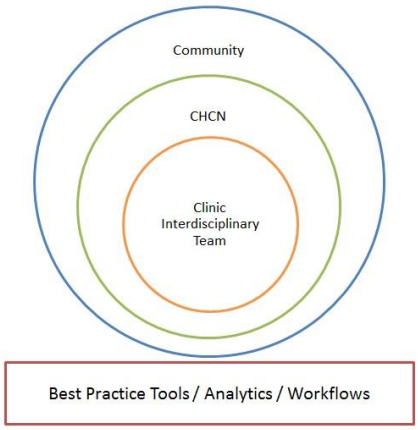
Inpatient Support
CHWs are notified in real time of an inpatient admission and work with CHCN inpatient RNs on discharge planning.

Embedded Care Team
Care is given by an embedded care team that includes a community health worker, who is the primary care coordinator.

Person Centered Care
CHWs employ a person centered approach and use techniques such as motivational interviewing, harm reduction, and trauma informed care to build meaningful relationships.

For questions about if a patient is eligible or to learn more about the program, please contact Laura Miller, Chief Medical Officer at CHCN at lmiller@chcnetwork.org

Care Neighborhood| Program Overview



Care Neighborhood (CN) is an innovative case management program for high risk members. Care is delivered by embedded clinic-based community health workers (CHWs), who are integrated into the medical home team. CHCN provides technical training and support, inpatient support and best practice training and tools. High risk members are connected to community resources to support needs around the social determinants.

Program Elements

CN consists of the following program elements:

- Embedded Interdisciplinary Care Team – An interdisciplinary team of social workers, community health workers and RN at the health center coordinates and manages the patient's care
- Case Management System - CHCN developed a case management system for CHWs. The system integrates claims, EHR and community data to drive workflow and help CHWs manage their high risk panel.
- Data Analytics - CHCN developed a predictive risk model to identify high risk patients. CHCN also provides monthly dashboards and is conducting an impact evaluation.
- Technical training and support - Experienced LCSWs train and provide consultative support for CHWs.
- Inpatient support - CHWs are notified in real time of an inpatient admission and work with CHCN inpatient RNs on discharge planning.
- Person centered care - CHWs employ a person centered approach and use techniques such as motivational interviewing, harm reduction, and trauma informed care to build meaningful relationships.

Why do we need a program like Care Neighborhood?

Total cost analysis of our members show that 70% of the dollars we spend on our members is for hospitalizations, which is concentrated in just 5% of our total members who had a hospitalization. These high risk patients often have needs around the social determinants, such as food and housing, which are often difficult to address in a standard office visit. Care Neighborhood is designed to provide additional support by connecting patients to eligible clinic and community resources that can address the social determinants.

How does Care Neighborhood work?

CHCN will identify high risk members. Providers can also refer. A CHW will outreach and conduct a basic assessment and enroll the member if he/she is a good fit for the program.

Care Neighborhood| Provider Support

1. **Refer patients that you think may be a good fit for the program**
   - Members must be managed by CHCN

Good Fit	Potentially Eligible	Not Eligible
• evidence of high utilization **(ideally, at least one inpatient admission in last 12 months)** or highly likely to be admitted in the next 30-60 days • evidence of complex, multiple chronic conditions (ideally, **chronic conditions >4)** • evidence of needs around the social determinants *in conjunction* with the above • Must be CHCN member	• patients with active substance use, severe dementia, acute/severe mental illness, homelessness may be referred to an outside case management program or a clinic based program such as IBH	• Existing case management • ESRD • ESLD • Cancer • Hospice • Violence • Medicare-Medi-cal • Health Pac

   - If you think a patient is a good fit for Care Neighborhood, please reach out to your Community Health Worker who will conduct a basic assessment and refer to CHCN for eligibility screening.
   - Keep in mind that the enrollment process can take a few weeks. A patient is not enrolled in Care Neighborhood until a face to face visit occurs and a relationship is established.

2. **Promote Care Neighborhood to the patient during office visit and introduce CHW**
   - First contact between an eligible patient and a care coordinator will most likely happen directly after a regularly scheduled office visit. Best practice is to do a warm handoff to the CHW (consider introducing the CHW by name, clarify that the CHW is part of the clinic and care team).

3. **Follow up as necessary on Care Neighborhood patients**
   - CHWs will document their visits and care plans in NextGen. Any actions requiring provider action will be sent via task to the provider.

4. **Encourage the interdisciplinary team to work with Care Neighborhood to support the patient**
   - The Care Neighborhood service is designed to provide additional support for high complex patients in conjunction with the interdisciplinary care team at the health center.

5. **Let us know how we can improve the program. Give feedback to your local CHW.**

Cultural Competency Training Resource

CHCN Cultural Humility Training can be found on the CHCN Provider Portal at:

https://connect.chcnetwork.org/Provider-Training

Electronic Consults for CHCN Health Center Providers

What is RubiconMD?

Community Health Center Network (CHCN) contracted with RubiconMD to provide electronic consults to all primary care providers (PCP) in CHCN's network. RubiconMD offers a **secure, web-based platform and smartphone application** for PCPs to submit specialty consultations prior to referring a patient for a specialty visit, much like a curbside consult. PCPs use RubiconMD as a tool for informal **peer-to-peer** discussion with specialists in order to **improve specialty referrals**. Providers can easily upload documents, labs, tests, clinical notes, and images from the electronic health record to RubiconMD's platform for quick and efficient consultation.

How does Econsult improve member care and save time and money?

Each CHCN provider has **unlimited** access to specialty consults and use of the platform. RubiconMD offers more than **105 specialty types**, including high-demand specialties such as dermatology, cardiology, and a variety of pediatric sub-specialties. Consulting with specialists from RubiconMD's network *prior* to referring the patient to a local specialist **reduces unnecessary referrals** and allows providers to manage the member's care. The average specialist **response time is between 2.5 and 4 business hours** on RubiconMD, a significant improvement from specialty appointments wait times of 2 weeks or more.

Partnership with Alameda Health System

Beginning in September 2016, CHCN partnered with **specialists from Alameda Health System** (AHS) to provide electronic consults in the following specialty areas:

- Cardiology
- Endocrinology
- Gastroenterology
- Neurology
- Pulmonology
- Rheumatology
- Urogynecology
- Urology

Opportunities for a "virtual curbside" with an AHS specialist will enhance CHCN and member health centers' relationships with **mission-aligned** colleagues at AHS. If an in-person consult is needed, providers may refer to AHS specialists or another provider of their choice in the network.

Quality Management

Healthcare Effectiveness Data and Information Set (HEDIS) are widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS is applicable to and measured by insurance lines, including commercial, Medicare, and Medicaid. HEDIS measures allow consumers to compare health plan performance to other plans, and to national or regional benchmarks. CHCN has financial incentive agreements with both plans, Alameda Alliance for Health (AAH) and Anthem Blue Cross (ABC), based on HEDIS performance. The list below contains HEDIS measures included in CHCN's current pay for performance programs with both health plans, AAH and ABC. For more information about HEDIS or Quality please contact Xiao Chen, Quality Management Manager at CHCN at xchen@chcnetwork.org.

CHCN HEDIS Measures and Description (2017)		
Diabetes	CDC - HbA1c Testing	HbA1c tested in the measurement year
	CDC - HbA1c ≤9.0%	A1c ≤ 9.0%
	CDC - HbA1c <8.0%	HbA1c control <8.0%
	CDC - Eye Exam	Retinopathy exam
Hypertension	CBP - BP Control	% BP in control
	MPM - ACEARB	Med Monitor ACE/ARB (ie K+/creat)
	MPM - Diuretics	Med Monitor diuretics (ie K+/creat)
Childhood	CIS	IZ done by second birthday
	W34	Well Child visits in 3 to 6 age range
	IMA	Immunizations for adolescents
Asthma	AMR	Asthma Medication ratio (total rate)
Women's Health	BCS	Mammo in past 2 years among women 52-74
	PPC - Pre	Pre-natal timeliness
	PPC - Post	Post-partum care timeliness
	CCS	Pap in last 3 years
Colorectal Cancer	CRC	CRC screen
HCM	N/A	Depression screening x x 3 NAH
	N/A	Tobacco screening
	N/A	HIV screen

Fraud Prevention: You Can Stop Fraud, Waste, and Abuse

What is Health Care Fraud?

Health care fraud includes but is not limited to, the making of intentional false statements, misrepresentations or deliberate omissions of material facts from any record, bill, claim or any other form for the purpose of obtaining payment, services, or any type of compensation for health care services for which you are not entitled.

Examples of Fraud

By a Member:

- Lending an Alliance ID card to someone other than the member;
- Pretending to be someone else to obtain services;
- Altering or forging a prescription;
- Concealing assets or income in order to gain coverage; and
- Falsifying information in order to obtain narcotic drugs.

By a Provider:

- Billing for services, procedures and supplies not rendered, or different from what was rendered, to the patient;
- Providing serviced to patients that are not medically necessary;
- Balance billing a Medi-Cal member for Medi-Cal covered services; and
- Unbundling or up-coding procedures.

By a Pharmacy:

- Billing for a brand name prescription when dispensing a generic;
- Dispensing a different medication than was prescribed;
- Altering the quantity of the prescription without proper documentation; and
- Buying back prescription drugs for resale.

Health care fraud, waste, and abuse cost taxpayers billions of dollars each year. You can help stop fraud by reporting it.

If you suspect fraud by our health plan, doctors, drug stores, or members, report it by calling:

- To report to CHCN: 510-297- 0407 or compliancemailbox@chcnetwork.org
- To report to Alameda Alliance for Health: 1-855-747-2234 or compliance@alamedaalliance.org
- To report to Anthem Blue Cross: Report online at https://mss.anthem.com/pages/wfa.aspx
- To report directly to Medi-Cal: 1-800-822-6222 or stopmedicalfraud@dhcs.ca.gov
- To report to California DHCS: 1-800-822-6222 or fraud@dhcs.ca.gov

For more information, please see the CHCN Provider Training on HIPAA, PHI, and Fraud, Waste & Abuse at https://connect.chcnetwork.org/Provider-Library/Provider-Relations

Thank you for helping us fight fraud, waste, and abuse.

GETTING TO THE HEART

WHAT WE DO

Strengthen trust among care team members by pairing MAs and providers in a series of lunch discussions. Pairs share who they are, what they value and how they work together. Later, review cases and how they might work differently.

WHY IT MATTERS

A trusting relationship builds a strong team, reduces burnout and helps patients - a triple win!

RELATE

Discover more about your colleague

COMMUNICATE

Explore issues that affect your relationship

TRUST

Overcome barriers that lead to frustration

ALAMEDA HEALTH CONSORTIUM

Kristalia Williams, Health Worker, III

Part of burnout is having strained relationships with people. I think burnout is about miscommunication, misjudgment , mis-a lot of stuff. So, breaking down those walls, whether it's a cultural barrier, whether it's language or personality, background barriers makes a difference. It's really important to be able to shed light and be honest, because you're "getting to the heart," you're not getting to the skin.

You get ignited with the joys of practice.

Michelle Carderelli, MA and Maya Ghorayeb, MD

Michelle and Maya have found that in the heat of a clinic day, knowing more about each other eases tempers. Michelle also expressed that knowing each other better helps set expectations for set up which creates a smoother clinic flow. Both believe that the value getting to know each other should not be underestimated.

They continue to take time to meet.

WHAT IT TAKES

Six MA-Provider one-on-one meetings for an hour (paid and with food) to establish better understanding and communication, using a workbook to guide the conversations. We **launch the program** at an all staff meeting to describe it and answer questions.

Requirements:
1) MA-provider dyads in place
2) Time for the meetings
3) Six paid extra hours per person
4) Six lunch coupons per person (we budgeted $7 per lunch)

RETURN ON INVESTMENT

Two health center sites have completed the program. In both, productivity rose, and in one, sick time went down. Pairs identified respect and trust as key elements, and were deepened in the course of the project. We also think that there is a difficult-to-measure, but palpable, rise in satisfaction for staff and MA confidence.

Interpretive Services

Medi-Cal managed care interpretive services are provided at no cost to the patient and available 24 hours a day, 7 days a week.

Alameda Alliance for Health:

Face-to-Face Interpreter Services

Call the Alliance Member Services department at **510-747-4567** or fax the Request for Interpreters Form to Alliance Member Services at **1-855-891-7172.**

The Alliance asks for **72 hours advance notice**. Same day requests may be possible for urgent situations.

Telephonic Interpreter Services

Call the Alliance's interpreter vendor, International Effectiveness Centers (IEC), at **1-866-948-4149**

Anthem Blue Cross:

Anthem members and providers may call the Customer Care Center at **(800) 407-4627** to schedule Face-to-Face or Telephonic interpreter services during business hours. Providers may also schedule by e-mailing **ssp.interpret@wellpoint.com**. Registration with our secure e-mail is required. Please type "secure" in the subject line. For members with hearing loss or speech impairment, call the TTY line at **(888) 757-6034.**

Anthem asks for **72 business hours** advanced notice to schedule services, and 24 business hours are required to cancel.

For Anthem members after-hours, call MedCall at **(800) 224-0336.**

2020 Interpreter Services Provider Update

At Alameda Alliance for Health (Alliance), we appreciate our provider-plan partnership to ensure that your Alliance patients have access to quality interpreters for all health care services. This packet contains important updates to Alliance interpreter services. We are rolling these changes out in three (3) phases.

THIS PACKET INCLUDES:

- Letter from Scott Coffin, Alliance CEO
- Provider Alert regarding our new telephonic interpreter services vendor, CyraCom
- Interpreter Services Provider Guide
- Interpreter Services Request Form
- Point to Your Language Card
- I Speak Cards

PHASE	DESCRIPTION	LAUNCH DATE
1	**For all Alliance Providers –** Launch of new telephonic interpreter services vendor, CyraCom.	June 1, 2020
2	**First group** of Alliance clinics/providers will begin to follow the new guidelines for in-person interpreter services. • Community Health Center Network (CHCN) clinics • Beacon Health Options providers **All Alliance providers** will need to submit requests for in-person interpreters Services five (5) business days in advance.	July 1, 2020
3	**Second group** of Alliance providers will follow the new guidelines for in-person interpreter services. • Children's First Medical Group • Alameda Health System • All other directly contracted clinics and providers	October 1, 2020

Questions? Below are ways that you can contact us for questions related to Alliance interpreter services:

- Contact the Health Education Manager:
  Linda Ayala
  Phone Number: **1.510.747.6038**
  Email: **layala@alamedaalliance.org**
- Call our Provider Call Center:
  Monday – Friday, 7:30 am – 5 pm
  Phone Number: **1.510.747.4510**
- Visit the provider section of our website:
  www.alamedaalliance.org/providers/provider-resources/language-access

ALAMEDA Alliance FOR HEALTH

June 22, 2020

Re: Interpreter Services for Alameda Alliance for Health Members

Dear Alliance Provider Partner,

At Alameda Alliance for Health (Alliance), we appreciate our dedicated provider community and the quality health care that you provide to our members. We understand that interpreter services are key to helping provide excellent care to our diverse membership. Almost 40% of our members prefer to communicate in a language other than English, and at many of our partner clinics, that percentage is significantly higher.

Over the next year, we will be moving most of our interpreter services from in-person to on-demand telephonic interpreting. We anticipate that increasing on-demand telephonic services will lift a significant administrative burden for you and your office staff. Telephonic interpreting services has the advantage of immediate access, and in most cases, there is no need to preschedule or confirm appointments.

To support this change, we will have a new vendor for telephonic interpreter services – CyraCom. They have specialized in health care interpretation for more than 25 years and provide on-demand services in over **230** languages.

Our planned on-demand telephonic interpreter services rollout date for Community Health Center Network (CHCN) and Beacon Health Options is Wednesday, July 1, 2020. For Children First Medical Group (CFMG), Alameda Health System (AHS) and all directly contract providers, the effective date is Thursday, October 1, 2020. In-person interpreter services will still be available for American Sign Language (ASL) and sensitive or complex health care visits. For in-person interpreters, providers will still need to complete an *Interpreter Services Appointment Request Form*, and fax it directly to the Alliance at least **five (5) business days** before the appointment.

In this packet you will find our updated instructions for accessing interpreter services. Please note the implementation date. If you have any questions, please contact our project lead:

Linda Ayala, MPH, Health Education Manager
Phone Number: **1.510.747.6038**
Email: **layala@alamedaalliance.org**

We remain committed to ensuring that our members have access to quality interpreter services at each health care encounter, and look forward to our continued partnership.

Sincerely,

Scott Coffin
Chief Executive Officer
Alameda Alliance for Health

Important Update Starting Monday, June 1, 2020: New Alliance On-Demand Telephonic Interpreter Services Vendor CyraCom

At Alameda Alliance for Health (Alliance), we value our dedicated provider partners and appreciate all of the hard work you do to protect the health and wellbeing in our community. We are excited to announce our new on-demand vendor for interpreter services, CyraCom.

Starting Monday, June 1, 2020, the Alliance will partner with CyraCom to provide on-demand telephonic interpreter services for our members. CyraCom has specialized in health care interpretation for more than 25 years and provides services in over 230 languages.

Telephonic interpreter services is the fastest and most efficient way to obtain an interpreter. To access services, please call **1.510.809.3986** and follow the prompts. This is the same phone number that we have always had for telephonic interpreter services.

The automated system will request the following:

1. **The PIN number for the network you are contracted with:**
   - If you are a **CHCN** provider – **1001**
   - If you are a **CFMG** provider – **1002**
   - If you are a **Beacon** provider – **1003**
   - If you are an **Alliance** provider – **1004**
2. **A number to request the language you need:**
   - For Spanish – press **1**
   - For Cantonese – press **2**
   - For Mandarin – press **3**
   - For Vietnamese – press **4**
   - For all other languages – press **0**
3. **The member's 9-digit Alliance Member ID number.**

Requesting an interpreter for Telehealth: CyraCom also offers interpretation for telehealth visits! When you are ready to connect to an interpreter, please call **1.510.809.3986**. Follow steps 1-3 above, and provide the telehealth phone number and log in information. The interpreter will then call in to join your telehealth visit.

For more information on interpreter services, including how to schedule American Sign Language (ASL), telephonic interpretation for less common languages, or in-person services, please contact:

Alliance Provider Services Department
Phone Number: **1.510.747.4510**
www.alamedaalliance.org/providers/provider-forms

Questions? Please call Alliance Health Programs
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4577**
www.alamedaalliance.org

HE_PRVDRS_CYRACOM 05/2020
FAXED/POSTED: 05/15/2020

At Alameda Alliance for Health (Alliance), we are committed to continuously improve our provider and member customer satisfaction. The Alliance provides no-cost interpreter services including American Sign Language (ASL) for all Alliance covered services, 24 hours a day, 7 days a week.

Effective Monday, June 1, 2020, please use this guide to better assist Alliance members with language services. Please confirm your patient's eligibility before requesting services.

TELEPHONIC INTERPRETER SERVICES

Common uses for telephonic interpreter services:

- Routine office and clinic visits.
- Pharmacy services.
- Free standing radiology, mammography, and lab services.
- Allied health services such as physical occupational or respiratory therapy.

To access telephonic interpreters:

1. Please call **1.510.809.3986**, available 24 hours a day and 7 days a week.
2. Provide the nine-digit Alliance member ID number.
3. For communication with a patient who is deaf, hearing or speech impaired, please call the California Relay Service (CRS) at **7-1-1.**

IN-PERSON INTERPRETER SERVICES

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

- Sign language for the deaf and hard of hearing
- Complex courses of therapy or procedures, including life-threatening diagnosis (Examples: cancer, chemotherapy, transplants, etc.)
- Highly sensitive issues (Examples: sexual assault or end of life)
- Other conditions by exception. Please include your reason in the request.

To request in-person interpreters:

1. You must schedule in-person interpreter services at least **five (5) business days** in advance. For ASL, **five (5) days** is recommended, but not required.
2. Please complete and fax the **Interpreter Services Appointment Request Form** to the Alliance at **1.855.891.9167**. To view and download the form, please visit **www.alamedaalliance.org/providers/provider-forms**.
3. The Alliance will notify providers by fax or phone if for any reason we *cannot* schedule an in-person interpreter.
4. If needed, please cancel interpreter services at least **48 hours** prior to the appointment by calling the Alliance Provider Services Department at **1.510.747.4510**.

PLEASE NOTE:
The Alliance discourages the use of adult family or friends as interpreters. Children should not interpret unless there is a life-threatening emergency and no qualified interpreter is available. If a patient declines interpreter services, please document the refusal in the medical record.

Questions? Please call Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone number: **1. 510.747.4510**

Interpreter Services Request Form

At Alameda Alliance for Health (Alliance), we provide no-cost interpreter services including American Sign Language (ASL) for all Alliance covered services, 24 hours a day, 7 days a week. Please confirm your patient's eligibility before requesting services. Please complete this form to request interpreter services.

INSTRUCTIONS

1. Please print clearly, or type in the fields below.
2. Forms must be submitted by fax at least **five (5) working days** prior to the appointment date. For ASL, **five (5) working days** is recommended, but not required.
3. Please return form by fax to the Alliance at **1.855.891.9167**.

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

SECTION 1: PATIENT INFORMATION

Full Name: _____ Alliance Member ID #: _____

Date of Birth (MM/DD/YYYY):_____ Phone Number: _____

SECTION 2: INTERPRETER SERVICE TYPE (CHECK ONLY ONE TYPE OF SERVICE)

☐ Telephone Interpreting by Appointment ☐ In-Person Interpreting

☐ Video Interpreting by Appointment *(if available at clinic location)*

Language: _____ Special Requests (optional): _____

SECTION 3: APPOINTMENT DETAILS

For in-person appointments, please include address information.
For prescheduled video or telephonic appointments, please provide call-in information and/or link.

Date (MM/DD/YYYY): _____ Start Time: _____ Duration: _____

Provider Name: _____ Provider Specialty: _____

Address (*include dept./floor/suite)*: _____

City: _____ State: _____ Zip Code: _____

Call-In Information/Link: _____

Please complete if requesting an in-person interpreter: What is the nature of the request?

☐ Complex course of therapy or procedure including life-threatening diagnosis *(Examples: cancer, chemotherapy, transplants, etc.)*

☐ Highly sensitive issues (*Examples: sexual assault, abuse, end-of life, etc.*)

☐ Other condition *(please include justification)*:

SECTION 4: REQUESTOR INFORMATION

Name: _____

Phone Number: _____ Date (MM/DD/YYYY): _____

Telephonic interpreter services are available for Alliance members at anytime, 24 hours a day, 7 days a week without an appointment by calling **1.510.809.3986**. To view and download this form, please visit **www.alamedaalliance.org/providers/provider-forms**.

"I SPEAK" CARDS

FOR ALLIANCE MEMBERS

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

The Alliance has created "I Speak" cards as a resource for our provider partners and members to use during doctor visits. This resource includes information to help Alliance members get an interpreter for their health care visits. Alliance members can show the card to your office staff to let them know what language they speak. It also has instructions on how your office can contact the Alliance to get an interpreter.

Furthermore, you can help your patients if you are sending them to receive other services such as laboratory or radiology. The "I Speak" card will let the medical office staff know how to call an interpreter for your patient. Alliance telephonic interpreters are available 24 hours a day, 7 days a week at **1.510.809.3986**.

INSTRUCTIONS

1. Please fill in the member's preferred language.
2. Ask the patient to show the card to the health care provider for help in their language.

Please see back to view samples of the "I Speak" card.

To request a supply of "I Speak" cards, please email Alliance Health Programs at **livehealthy@alamedaalliance.org**. Please provide your name, clinic, mailing address, phone number, and quantity needed for each language. I speak cards are available in English, Spanish/English, Chinese/English and Vietnamese/English.

Thank you for partnering with us to ensure that our members are receiving care in their language!

ALAMEDA Alliance FOR HEALTH

Questions? Please call Alliance Health Programs
Monday - Friday, 8 am - 5 pm
Phone Number: **1.510.747.4577**
www.alamedaalliance.org

SAMPLES OF "I SPEAK" CARDS*

ENGLISH CARD - USE FOR ANY LANGUAGE

Front

ALAMEDA Alliance FOR HEALTH

I Speak: _____

PLEASE CALL AN INTERPRETER.
Thank You.

Back

Providers: To request a phone interpreter on demand, please call **1.510.809.3986**.

Alameda Alliance for Health (Alliance) members can receive interpreter services for covered health care services.

Please have the member ID ready.

Members: For any questions, please call the Alliance Member Services Department at **1.510.747.4567**.

BILINGUAL CARD - AVAILABLE IN SPANISH, CHINESE AND VIETNAMESE

Front

ALAMEDA Alliance FOR HEALTH

I speak Spanish

PLEASE CALL AN INTERPRETER.
Thank you.

Back

Providers: To request a phone interpreter on demand, please call **1.510.809.3986**.

Alameda Alliance for Health (Alliance) members can receive interpreter services for covered health care services.

Please have the member ID ready.

Members: For any questions, please call the Alliance Member Services Department at **1.510.747.4567**.

Inside

ALAMEDA Alliance FOR HEALTH

Yo hablo español

LLAME A UN INTÉRPRETE.
Gracias.

Proveedores: Para solicitar el servicio de interpretación por teléfono por encargo, llame al **1.510.809.3986**.

Los miembros de Alameda Alliance for Health (Alliance) pueden recibir servicios de interpretación para los servicios de cuidado de la salud cubiertos.

Tenga a la mano su número de identificación del miembro.

Miembros: Si tiene alguna pregunta, llame al Departamento de Servicios al Miembro de Alliance al **1.510.747.4567**.

*Actual "I Speak" Cards are standard business card size.

Point to your language. We will get you an interpreter.

Arabic اللغة العربية أشر الى لغتك وسنتادى المترجم حالا	**Laotian** ພາສາລາວ ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້ ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້
Cambodian ភាសាខ្មែរ សូមចង្អុលភាសារបស់អ្នក យើងនឹងហៅអ្នកបកប្រែមកជូន	**Mam** Mam Yectz tyola. K,o co jel yolon tejun xal toj tell tyola.
Cantonese 廣東話 請指認您的語言 以便為您請翻譯	**Mandarin** 國語 請指認您的語言 以便為您請翻譯
Dari دری شما به کدام زبان گپ می زنید؟ یک ترجمان می آید.	**Mien** Mienh Nuqv meih nyei waac mbuox yie liuz, yie heuc faan waac mienh bun meih oc.
Eritrean ትግርና ናብቃንቃኹም ኣመልክቱ ኣተርጎሚ ክድወለሉ እዩ	**Pashto** پښتو خپله ژبه وښیه. ژر به ترجمان درسره خبری وکړ.
Ethiopian አማርና ወደቓንቓው ኣያመልክቱ ኣስተርጓሚ ኣንጠራለን	**Punjabi** ਪੰਜਾਬੀ ਅਪਣੀ ਬੋਲੀ ਇਸ਼ਾਰੇ ਨਾਲ ਦਸੋ । ਤੁਹਾਡੇ ਵਾਸਤੇ ਪੰਜਾਬੀ ਬੋਲਣ ਵਾਲਾ ਬੁਲਾਇਆ ਜਾਏਗਾ ।
Farsi فارسی به زبانی که صحبت می کنید اشاره کنید، برای شما مترجم می آوریم.	**Russian** Русский Язык Укажите, на каком языке Вы говорите. Сейчас Вам вызовут переводчика.
Hindi हिंदी अपनी भाशा इशारे से दिखाइये । आपके लिए दुभाशिया बुलाया जाऐगा ।	**Spanish** Español Señale su idioma. Se llamará a un intérprete.
Hmong Hmoob Thov taw tes rau koj yam lus. Peb yuav hu ib tug neeg txhais lus rau koj.	**Tagalog** Tagalog Ituro mo ang iyong wika. Matatawagan ang tagapag-salin.
Indonesian Bahasa Indonesia Tunjukkan bahasamu. Jurubahasa akan disediakan.	**Thai** ภาษาไทย ช่วยชี้ให้เราดูหน่อยว่า ภาษาไหนเป็นภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน
Japanese 日本語 あなたの話す言語を指で、示してください。 通訳をお呼びします。	**Urdu** اردو زبان مین بات کرنا پسند کرینگی؟ سی آپ کون آپ کی مدد کیلے آپہی کی ترجمان کو بلایا جاہے گا.
Korean 한국어 당신이 쓰는 말을 지적하세요. 통역관을 불러 드리겠어요.	**Vietnamese** Tiếng Việt Chỉ rõ tiếng bạn nói. Sẽ có một thông dịch viên nói chuyện với bạn ngay.

Member Grievances (Complaints) and Appeals

Members may report complaints, grievances, or appeals by contacting the health plan. Providers may provide members with a Grievance Form that can be mailed or faxed to the health plan. Once the member's grievance or appeal is logged the health plan will investigate and provide the member with a resolution. In some cases, health plan or CHCN may request information from our providers to assist with reviewing a member's grievance or appeal.

Alameda Alliance for Health

- By phone: 1-877-932-2738; CRS for hearing impaired at 711 or 1-800-735-2929
- In writing: Fill out a complaint form or write a letter and send it to:
  Alameda Alliance for Health
  G & A Unit
  1240 Loop Road
  Alameda, CA 94502
  Fax 1-855-891-7258

Anthem Blue Cross

- By phone: 1-800-407-4627
- In writing: Fill out a complaint form or write a letter and send it to:
  Attn: Grievance Coordinator
  Anthem Blue Cross
  P.O. Box 60007
  Los Angeles, CA 90060-0007
  Fax 1-888-387-2968

Member Services Department
P.O. Box 2818
Alameda, CA 94501-0818
Tel: 510-747-4567 or 1-877-371-2222
Fax: 1-855-891-7258
CRS/TTY: 711 or 1-800-735-2929
www.alamedaalliance.org

MEMBER GRIEVANCE FORM*

Member Name		Alliance Member ID #
Address Street		City Zip
Day Telephone Number	Alternate Telephone Number	Date of Birth
Name of Person Filing Grievance (if not the same person as above)		Telephone Number
Where Incident Occurred		Date Incident Occurred

Please describe the problem you had.

(attach extra pages if needed)

How have you tried to resolve this problem?

What do you think is a good solution to your problem?

Signature Date

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 510-747-4567 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made be a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

***If you need help with this form call 510-747-4567.**

Member Grievance Form

Please complete this form and attach any related documents. Mail the form and documents to: **Attn: Grievance Coordinator, Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007.**

You may also file a grievance by calling the Customer Care Center or Member Services phone number on your Anthem Blue Cross ID card. You will be sent a response within 30 calendar days of us receiving this form or your call.

Date: _____

Member Name: _____ Member ID Number/CIN Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

Information about the Grievance

This information becomes part of the permanent record; write clearly and legibly.

Date of Incident: _____

Describe What Happened (Attach additional pages if necessary.):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature of Member (Parent or guardian if the member is a minor.)

X _____ Date: _____

If you need assistance with this form, please call the Customer Care Center or Member Services phone number on your Anthem Blue Cross ID card. Please see the back of this form for more information.

Blue Cross of California, doing business as Anthem Blue Cross, is contracted with L.A. Care Health Plan to provide Medi-Cal managed care services in Los Angeles County. In all other areas, Medi-Cal managed care services are provided by Blue Cross of California Partnership Plan doing business as Anthem Blue Cross Partnership Plan. Independent licensees of the Blue Cross Association.
® ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.

All Medi-Cal Members

You may also ask for a State Fair Hearing within 90 days of the incident. Write to:

Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

You may call the Department of Social Services directly at **1-800-952-5253**. You may call the Office of the Ombudsman to assist you at **1-888-452-8609**.

Healthy Families Program Members

Your Anthem Blue Cross Benefit Agreement contains an arbitration clause. Any dispute between you or your representative and Anthem Blue Cross, or its affiliates, that exceeds the small claims court jurisdictional limits must be resolved through arbitration. To initiate arbitration, a written request must be submitted to:

Attn: Appeals and Complaints Department
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Upon receipt, your request will be acknowledged and you will receive further information regarding the arbitration process.

Los Angeles County Medi-Cal Members

You may also contact the following:

Attn: Member Services
L.A. Care Health Plan
555 W. Fifth Street
Los Angeles, CA 90013
1-888-452-2273

You may call the Office of the Ombudsman to assist you at **1-888-452-8609**. You may also ask for a State Fair Hearing within 90 days of the incident. Write to:

Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

You may call the Department of Social Services directly at **1-800-952-5253**.

Upon receipt, your request will be acknowledged and you will receive further information regarding the arbitration process.

All Anthem Blue Cross Members

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-407-4627** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Transportation Services

Medi-Cal transportation services are provided when medically necessary at no cost to the patient. Transportation benefits are managed by the Medi-Cal health plans, Alameda Alliance for Health (AAH) and Anthem Blue Cross (ABC).

Medical transportation is allowed to transport members to medically necessary services, including to pick-up prescription drugs that cannot be mailed and other medical supplies, prosthetics, orthotics and equipment. There are two types of transportation services: non-medical transportation (NMT) and non-emergency medical transportation (NEMT). Both are described below.

Effective October 1, 2017, transportation is also allowed for any medically necessary Medi-Cal benefits, including services not covered directly by the managed care plan, such as specialty mental health and dental services.

Additional information can be found in the All Plan Letter from Department of Health Care Services at http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Non-Medical Transportation (NMT)

Modalities:

- Taxi, public transit, East Bay Paratransit, private vehicle mileage reimbursement
- The least costly method of transportation that meets the member's needs will be provided
- NMT is available to members using a wheelchair so long as the member can ambulate without assistance from the driver

NMT does not require provider certification. Members may request NMT by contacting LogistiCare directly. If a provider wishes to request NMT on behalf of the member, they may do so using the Physician Certification Statement (PCS) Form, attached.

Non-Emergency Medical Transportation (NEMT)

NEMT is covered only when a recipient's medical and physical condition does not allow that recipient to travel by bus, passenger car, taxicab, or another form of public or private conveyance. Criteria follows:

- NEMT is provided to members who cannot reasonably ambulate, stand, or walk without assistance, including those using a walker or crutches for medically necessary covered services
- NEMT is required when the member cannot take ordinary public or private means due to medical and physical condition and when transportation is required for obtaining medically necessary services
- Plans must ensure door-to-door assistance for members receiving NEMT services, and plans must provide transportation for a parent or guardian if the member is a minor

Modalities:

1. **Ambulance Services**
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation

- Transfers from an acute care facility to another acute care facility except when member is transferred immediately following an inpatient stay to a skilled nursing facility or intermediate care facility
- Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
- Transport for members with chronic conditions who require oxygen if monitoring is required

2. **Litter Van Services**
    - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance
3. **Wheelchair Van Services**
    - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport
    - Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance

    Members with the following conditions may qualify with a Physician Certification Statement:
    - Members who suffer from severe mental confusion
    - Members with paraplegia
    - Dialysis recipients
    - Members with chronic conditions who require oxygen but do not require monitoring
4. **Air** – only when ground transport is not feasible

How to Request NEMT

Effective July 1, 2017, both health plans require a Physician Certification Statement (PCS) Form to request NEMT services.

- A physician, advanced practice professional, dentist, or mental health provider may request NEMT services using the health plan's Physician Certification Statement (PCS)
- For AAH and ABC members, submit the PCS request form directly to LogistiCare

Attachments

AAH PCS Form
ABC PCS Form

ALAMEDA Alliance FOR HEALTH

Physician Certification Form – Request for Transportation

For NEMT only, the physician must sign this form where indicated below. Please print clearly.
*Required fields must be completed. Please return form by fax to LogistiCare – Attn: Utilization Review **877.457.3352**.

PATIENT INFORMATION	
*PATIENT'S NAME	*PATIENT'S DOB
*PATIENT'S ID NUMBER/CIN#	MEMBER'S CONTACT NUMBER
DIAGNOSIS	
DIAGNOSIS	ICD CODE

TRANSPORTATION NEEDS (*Please check ONLY ONE level of service in either NEMT or NMT section)

Non-Emergency Medical Transportation (NEMT)
NEMT includes transportation by ambulance, wheelchair, and gurney vans for medically necessary covered services, specifically when the patient is non-ambulatory.

Check the applicable level of service needed:
- ☐ Wheelchair Van
- ☐ Ambulance/Litter Van/Gurney Van (Patient bed bound)
- ☐ ALS (Patient requires ALS services/availability)
- ☐ CCT/SCT (Patient requires cardiac monitoring)
- ☐ LS (Patient requires oxygen not self-administered or regulated)
- ☐ Air Transport

Non-Medical Transportation (NMT)
NMT includes transportation provided via taxi, car or other public conveyances for medically necessary covered services. *No signature is required for NMT*.

Check the applicable level of service needed:
- ☐ Public Transportation/Mass Transit
- ☐ East Bay Paratransit
- ☐ Curb-to-Curb Vehicle Transportation (Taxicab)
- ☐ Door-to-Door Vehicle Transportation
- ☐ Private Vehicle arranged by patient*

**Additional verification information needed for approval.*

***DURATION (Based on medical necessity and continued health plan eligibility)**

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 6 Months ☐ 12 Months

FUNCTION LIMITATIONS JUSTIFICATION

When transportation is requested for an ongoing basis, the chronic nature of the patient's medical, physical, or mental health condition must be indicated in the treatment plan. A diagnosis alone will not satisfy this requirement. Treatment plan should include the medical, behavioral health, or physical condition that prevents normal public or private transportation. **NMT services do not require physician signature and will be approved based on the least costly method of transportation that meets the member's needs.**

***PLEASE INCLUDE YOUR JUSTIFICATION BELOW:**

CERTIFICATION FOR NON-EMERGENCY MEDICAL TRANSPORTATION

The provider responsible for providing care for the member is responsible for determining the medical necessity for transportation. This certificate can be completed and signed by a MD, DO, PA, or NP, CNM, Physical Therapist, Speech Therapist, Occupational Therapist, or Mental Health or Substance Use Disorder Provider who is employed or supervised by the hospital, facility, or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate, except for requests relating to hospice or home health services, which must be signed by an MD or DO.

Provider's Name & Credential (Print):	**Date:**
Provider's Signature:	**Phone Number:**

Questions? Please call the LogistiCare's California Facility Department at **866.529.2128**

Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

Physician Certification Statement — Transportation Justification Request

This form provides LogistiCare or another authorized transportation provider with information about the appropriate level of nonmedical transportation (NMT) or nonemergency medical transportation (NEMT) needed for the member. Please return the completed form by fax to LogistiCare at **1-877-457-3352**, Attn: Utilization Review.

Patient name (Print clearly.): _____

Member ID number: _____ DOB: _____

Please check only **one** medically necessary mode of NMT. **Note:** A physician's signature **is not** required for NMT.

1. **NMT** includes transportation for medically necessary appointments and may be provided via taxi, sedan, paratransit (such as access) or fixed route transportation (such as a bus).
   - ☐ **Mass transit**: Patient/member is able to use public transportation and medically able to walk up to three-quarters of a mile to a bus stop (curb to curb).
   - ☐ **Paratransit services**: Patient/member (already certified, qualified or eligible to apply) can walk to the curb and board and exit a vehicle unassisted but cannot utilize the bus or train (curb to curb).
   - ☐ **Ambulatory (sedan, taxi)**: Patient/member can walk to the curb and board and exit the vehicle unassisted but cannot utilize the bus or train (curb to curb).
   - ☐ **Ambulatory door to door (sedan)**: Patient/member can walk but requires driver assistance from their residence to the medical appointment (door to door).
     - ☐ Wheelchair (able to transfer from a folding position without assistance)
       Note: If assistance is needed, please choose the wheelchair van option under NEMT instead.
     - ☐ Walker ☐ Cane ☐ Crutches

Please check only **one** medically necessary mode of NEMT. **Note:** A physician's signature **is** required for NEMT.

NEMT includes ambulances, wheelchair vans and gurney vans and is provided when medically necessary and the patient is not ambulatory. NEMT transportation under Medi-Cal Managed Care is covered only when the patient's medical and physical condition does not allow him or her to travel by bus, passenger car, taxi or another form of public/private vehicle.

- ☐ **Wheelchair van**: Patient/member uses a power or electric wheelchair and requires a lift-equipped vehicle and driver assistance.
- ☐ **Stretcher/gurney van**: Patient/member is confined to bed, cannot sit in a wheelchair and does not require medical attention/monitoring during transport.
- ☐ **Basic life support ambulance**: Patient/member is confined to bed; cannot sit in a wheelchair; and requires medical attention/monitoring during transport for reasons such as isolation precautions, nonself-administered oxygen or sedation.
- ☐ **Advanced life support ambulance**: Patient/member is confined to bed; cannot sit in a wheelchair; needs advanced life support; and requires medical attention/monitoring during transport for reasons such as intravenous device monitoring, cardiac monitoring or tracheotomy.
- ☐ **Air transport**: Patient/member's medical condition is such that transport by ordinary means of private or public ground transportation is medically contraindicated.

2. Please justify the mode of transportation chosen above with a medical purpose specific to visit(s), including functional limitations that preclude the patient's ability to ambulate without assistance or be transported by private/public vehicle:

3. Duration of services (based on continued eligibility): ☐ 30 days ☐ 60 days ☐ 90 days ☐ 12 months

Certification statement: The physician, dentist or podiatrist responsible for providing care for the member is responsible for determining medical necessity for transportation. This certificate can be completed and signed by a participating physician group, independent practice association, PCP, MD, LVN, RN, PA, NP or discharge planner who is employed or supervised by the hospital, facility or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate. A completed and approved physician certification statement form may not be modified.

Staff/Physician's Name: _____

Staff/Physician's Signature: _____ Date: _____

Title: _____ Contact Phone: _____

https://mediproviders.anthem.com/ca Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Blue Cross of California Partnership Plan, Inc. are independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. Blue Cross of California is contracted with L.A. Care Health Plan to provide Medi-Cal Managed Care services in Los Angeles County.

CHCN's Utilization Management Process

CHCN's prior authorization requirements are applicable to all members. If a rendering provider (the provider who rendered care to a patient) does not receive an authorization approval number from CHCN, claims may not be reimbursed. CHCN providers may submit prior authorizations via fax or online via CHCN's provider portal, Connect. CHCN's current prior authorization requirements as well as prior authorization form can be found on the CHCN portal https://connect.chcnetwork.org/UM-Authorizations-Resources

Inpatient Admissions Requirements

- For Alameda Alliance members, all inpatient facilities must notify CHCN within 24 hours, but no later than the end of the next business day of all inpatient admissions.

  For Anthem Blue Cross patients, all inpatient facilities must notify Anthem Blue Cross at Fax: (866) 333-4826

- Admission ***face sheet notifications*** should be faxed to our Inpatient Care Transition (ICT) unit at 510-297-0444.
- Notifications not received by our ICT unit within the noted timeframe may result in a facility denial of the inpatient authorization for service and payment.

Timely Concurrent Review

- CHCN uses MCG and health plan appropriate evidenced-based guidelines to perform initial and concurrent review of all inpatient admissions.
- Upon request, facilities should fax concurrent ***clinical information*** to the ICT unit via fax at 510-297-0449, by the end of the next business day from the time of the request.
- Clinical information insufficient to render a medically necessary determination, or clinical information not received within this timeframe, may result in a facility denial of the inpatient authorization for the service and payment.

Denial of Inpatient Services

- CHCN may deny any inpatient admission by contracted facilities if notification of the admission is not received by the end of the next business day.
- CHCN may deny any admission or days of inpatient care if sufficient clinical information for concurrent review is not received by the end of the next business day.
- CHCN may deny inpatient days should clinical information submitted not support MCG CARE GUIDELINES criteria for continued stay.
- CHCN will issue a notice of denial for inpatient services to the facilities clinical representative or department by the end of the day in which the denial is effective.
- Upon notification of a denial of inpatient services, the facility's clinical representative may initiate an appeal of the denial to CHCN and/or the health plan.

Notification of Stays for Observation

CHCN requires all facilities to submit immediate notification when a member is admitted for a hospital or observation stay. Additionally, separate notification to CHCN is requested when an observation stay converts to an inpatient admission. Please send all Inpatient Admission and Observation Stay notifications to our ICT unit via fax at 510-297-0444.

In addition to notification methods described above, CHCN provides a written notice of the authorization decision to the provider within two (2) business days of the date of decision. Member, member's representative and providers will receive notification of the authorization decisions within two (2) business days if the decision is to deny, delay or modify the requested service. The notification letter includes the scope of services approved, the amount of services and the duration of service.

When there is insufficient information and a decision cannot be reached within the initial designated timeframe, the request will be deferred while medical information is gathered from the requesting physician. If CHCN cannot make a decision to approve, modify, or deny the request for authorization, within the timeframes specified above CHCN will notify the provider and the member in writing and specify the clinical information necessary to render a decision. The written notification will also notify the member and provider of the anticipated date on which a decision may be rendered.