August 27, 2026

Speech and Occupational Therapy Prior Authorization Guidelines

New Process Effective July 1, 2026

All speech and occupational therapy require prior authorization.

New Authorization- Child Not Previously seen for Speech or Occupational Therapy (OT)

- PCP continues to make initial authorization requests for speech or OT evaluation and CFMG authorizes.
- When evaluation is completed, **CFMG receives the evaluation and proposed treatment plan from the speech/occupational therapist and CFMG reviews** and authorizes the first round of visits. This is normally 26 visits over six months.

Child in Treatment for Continuation of Care

- **When the initial 26 visits are completed the speech/occupational therapist will submit clinical notes and request for continuation of treatment to the member's PCP.**
- After reviewing the clinical notes, **the PCP would make the determination that continued treatment is necessary. If the child has had an evaluation in the last year a new evaluation is not necessary unless the PCP deems it necessary.**
- **The PCP office submits an authorization request with the clinical notes from the vendor to CFMG** specifying the number of visits requested for continuation of treatment.
- CFMG will review the request using Milliman Care Guidelines.

Note: If member is dissatisfied with PCP's decision about speech and OT they can file a grievance with Alameda Alliance.

Alameda Alliance Update on Transportation Benefit

Medi-Cal Transportation Benefit
AAH members get transportation to medical appointments and services at no cost.
The Alliance covers two (2) types of ride services:

1. **Non-medical transportation (NMT)**
2. **Non-emergency medical transportation (NEMT)**

Non-Medical Transportation (NMT)

- Pick up prescriptions and medical supplies
- Travel to and from medical appointment authorized by provider

The Alliance NMT service benefit covers the use of car, taxi, bus, or other public/private way to get to a medical appointment.

Non-Emergency Medical Transportation (NEMT)
NEMT is for members who are not able to get to their medical appointment (Medical, mental health, dental, or substance use disorder treatment) by car, bus, train, taxi, or other NMT level of service.
NEMT uses the following levels of service:

- Air transport
- Litter/gurney van
- Ambulance
- Wheelchair van

The doctor must complete and submit the Physician Certification Statement (PCS) Form to the Alliance before a NEMT request. After the form is sent to the Alliance, the member or doctor can schedule transportation using the numbers:

- Alliance Member: **1-866-791-4158**
- An Alliance provider calling on behalf of an Alliance member: **1-866-529-2128**
- An Alliance provider who needs to report real-time concerns: **1-866-779-0569**

The **PCS form** can be found on the Alliance website under Provider Forms Transportation. Provider Forms - Alameda Alliance for Health

Timely Access and Alameda Alliance Provider Appointment Access Survey starts 9/21/2026 – please see the attachment

Highlights:

- PCP/specialist urgent appointment (no authorization) – 48 hours
- Non-urgent PCP appointment – 10 business days
- Non-urgent specialist appointment – 15 business days

CFMG Updates Milliman Guidelines

Children First Medical Group INC (CFMG) values our dedicated provider partner community. We have an important reminder that we would like to share with you.

Effective Monday March 3, 2026, CFMG updated to the 30th edition of the Milliman Care Guidelines (MCG) for the following modules:

· Inpatient & Surgical Care (ISC)

- 6 Guideline titles have content revisions with significant content changes General Recovery Care (GRC)
- 6 Guideline titles have content revisions with significant content changes Ambulatory Care (AC)
- 2 Guideline titles have content revisions with significant content changes

Please Note: The list above is a high-level summary of the updates and is not intended to be all inclusive. For more information and to view the complete 30th edition of the MCG Care Guidelines, please see the attached document from MCG titled Job Aid: 30th Edition Summary of Changes.

HEDIS: W15 and Lead Screening

W15 Measure – 6 visits up to 15 month birthday

The HEDIS **Well Child visit measure (W15) requires up to 6 visits, 14 days apart by the fifteenth month birthday.**

Use the Bright Futures guidelines to track recommended milestones and services needed for each well-child check-up. Bright Futures recommends **9 visits listed up to the 15th month**.
Bright Futures link:
https://tinyurl.com/yj28udmv

CFMG will send **a monthly report from the Alliance** listing members in this measure and the dates of services based on claims data**. If a member has 5 documented visits, please review if a sixth visit was scheduled but not listed and can be captured through an EMR record.** Please contact sharon.wright@ucsf.edu if any questions.

CFMG is striving to reach the 50th percentile for this measure. Please let us know how we can best support you.

Lead Screening

Medi-Cal requires lead screening at:

- 12 months
- 24 months

HEDIS requires at least one lead screening by the 2nd birthday. If you do lead screening at 12 months that will meet the HEDIS requirement for one screening **by the second birthday**.
The lead screening CPT code in the office is CPT 83655.

Notice of Privacy Practice

Providers covered under HIPAA and having a direct treatment relationship with patients should provide patients with a notice of privacy practices that explains the member's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgement that the patient received the notice of privacy practices.

Contracted providers under Managed Medi-Cal should respect the privacy of health plan members and comply with all applicable laws and regulations regarding the privacy of the Member-protected health information. Providers will give Notice of Privacy Practices to the new and existing members.

Confidentiality

CFMG Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable Federal and State regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Medical records are protected from unauthorized access.
- Access to computerized confidential information is restricted.

- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and social determinants of health is protected.

Thank you for taking care of the children and for all you do!

Important Reminder: 2026 Provider Appointment Availability Survey (PAAS) – September 2026 through December 2026

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction. We have an important reminder to share with you.

QMetrics on behalf of the Alliance, will administer the Provider Appointment Availability Survey (PAAS) annually. All health plans in California must survey providers to assess the availability of routine and urgent appointments.

About The PAAS Survey

Providers: Alliance network providers include primary care providers (PCPs), non-physician medical practitioners, specialist physicians, psychiatrists, non-physician mental health (NPMH) providers, and ancillary providers (imaging/radiology or physical therapy).

Methodology: The Alliance contacts a randomized sample (and oversample, as appropriate) of contracted network providers as of **January 14 of the current year**. The Alliance will first fax or email the PAAS survey. We encourage our provider partners to respond to the initial fax or email survey request to avoid additional outreach phone calls. If we do not receive a fax or email response within the first week of the survey request, the Alliance will follow up with a phone call.

Aside from the methodology above, providers have the option to participate in electronic data extraction for the survey. For more information, please reach out to the Alliance.

Questions: The survey solicits answers about the next available appointment[1] date and time for:

1. **Urgent and non-urgent services** for PCP, specialist physicians, psychiatrist, and NPMH providers
2. **Non-urgent services** for ancillary providers

Appointment dates and times are collected at the location level for those providers practicing at Federally Qualified Health Centers (FQHCs).

Provider offices are **contractually obligated** to complete the survey. Please note that non-responsiveness or refusal to comply with the survey may result in a corrective action plan.

This notice includes the required appointment time frames (Timely Access Standards).

We appreciate your attention and assistance in completing the PAAS.

Thank you for your continued partnership. We appreciate the high quality care you provide your patients and our members. Together we are creating a healthier community for all.

[1] Appointments can be either in-person or via telehealth.

Timely Access Standards

Alameda Alliance for Health (Alliance) is committed to working with our provider network in offering our members the highest quality of health care services.

Timely access standards* are state-mandated appointment timeframes for which you are evaluated. The timeframes are for Alameda Alliance Wellness (HMO D-SNP) and Alliance Medi-Cal.

All providers contracted with the Alliance are required to offer appointments within the following timeframes:

Appointment Wait Times (Medi-Cal)	
Appointment Type:	**Appointment Within:**
PCP/specialist urgent appointment that *does not* require PA	48 hours
PCP/specialist urgent appointment that *requires* PA	96 hours
Non-urgent **primary care** appointment (including OBGYN as PCP)	10 business days
First prenatal visit	2 weeks of request
Non-urgent appointment with a **specialist physician** (includes OBGYN specialty care)	15 business days of request
Non-urgent appointment with a **behavioral health provider**	10 business days of request
Non-urgent appointment for **ancillary services** for the diagnosis or treatment of injury, illness, or other health conditions	15 business days of request
Appointment Wait Times (D-SNP)	
Appointment Type:	**Appointment Within:**
Urgently needed services or emergencies that *do not* require PA	Immediately
Non-urgent **primary care** appointment	7 business days of request
Routine or preventive care	30 business days of request
All Provider Wait Times/Telephone/Language Practices	
Timely Access Category:	**Timely Access Standard:**
In-office wait time	60 minutes
Call return time	1 business day
Time to answer call	10 minutes
Telephone access – Provide coverage 24 hours a day, 7 days a week.	
Telephone triage and screening – Wait time not to exceed 30 minutes.	
Emergency instructions – Ensure proper emergency instructions.	
Language services – Provide interpreter services 24 hours a day, 7 days a week.	

*Per the California Department of Managed Health Care (DMHC) and California Department of Health Care Services (DHCS) regulations, and the National Committee for Quality Assurance (NCQA) Health Plan (HP) Accreditation standards and guidelines.

MA D-SNP = Medicare Advantage Dual Special Needs Plan

Non-urgent Care – Routine appointments for non-urgent conditions.

PA = Prior Authorization

Triage (or screening) – The assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to triage or screen and determine the urgency of the member's need for care.

Shortening or Extending Appointment Timeframes – The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

Urgent Care (or urgent services) – Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).