

PROVIDER MANUAL

October 2025

Table of Contents

	Page
CHAPTER 1 INTRODUCTION	3
A Message From Provider Network Services	
Omnicare: A Company Overview	
CHAPTER 2 – PROVIDER NETWORK SERVICES	6
Provider Network Services	
Management Company- Altura MSO	
CHAPTER 3 – MEDICAL MANAGEMENT	10
Case Management	
Utilization Management	
Referrals/Authorization	
CHAPTER 4 – PROVIDER RESPONSIBILITIES	13
Provider Responsibilities	
CHAPTER 5 - CLAIMS	17
Billing Guidelines	
Provider Disputes	
Balance Billing Guidelines	
CHAPTER 6 – MEMBER RIGHTS	20
Member Rights	
CHAPTER 7 URGENT CARE LOCATIONS	22
Urgent Care listing	
CHAPTER 8 – CULTURAL LINGUISTICS	25
Interpreting Services – Health Plan numbers	
CHAPTER 9 – TRAININGS/EDUCATION	27
Balance Billing	
Fraud, Waste and Abuse Material	
Palliative Care Guidelines for Coordination and Referral	
CHAPTER 10 – CONTACT INFORMATION	29
Omnicare Support Contacts	
APPENDIX	30
- Altura Authorization Request Form	
- Provider Network Oversight Policy: Access and Availability Standards	
- Provider Data Validation Form	
- Balance Billing Training	
- Fraud, Waste and Abuse Training	
- Palliative Care Guidelines for Coordination and Referral	

Chapter 1

Introduction



October 2025

Dear Valued Provider:

Welcome to Omnicare Medical Group!

As a valued member of our progressive network of healthcare providers serving Compton, Lynwood, and surrounding communities, we thank you for your commitment to delivering quality care to our members.

This Provider Manual contains important information about working with Omnicare, including guidance on submitting referral authorizations and claims. We encourage you to review all sections carefully—especially the Provider Responsibilities section—to ensure your practice remains in full compliance with Omnicare policies, as well as applicable state and federal regulations.

Please note: This Manual is a living document and will be updated periodically to reflect changes in Omnicare practices, legislation, and Health Plan requirements. We recommend that you review updates regularly to stay informed.

We appreciate your partnership and look forward to a long, collaborative relationship as we work together to provide exceptional healthcare services to our members.

If you have any questions, please contact your assigned Provider Network Administrator or reach out to Omnicare directly at (310) 900-4280.

Sincerely,

Corey Moffatt

Corey Moffatt
Director, Provider Network Administration
Altura Management Services

OMNICARE: A COMPANY OVERVIEW

The Company

Omnicare Medical Group once was started and operated by a group of dedicated physicians committed to providing quality healthcare to the citizens in the Lynwood, Compton and surrounding communities. Currently, with a network of 125 Primary Care Physicians and over 300 Specialty Providers, Omnicare serves approximately 38,000 lives. Our membership is expected to grow by expanding our relationship with other healthcare partners. Our core hospitals are St. Francis Medical Center and Long Beach Memorial Medical Center.

The transition of ownership to AltaMed Health Services in 2016 provided additional resources for continued growth and quality services for our membership. The officers for Omnicare Medical Group are as follows: Cristian Rico, MD, President; Rashi Hemnani, VP IPA Network Operations; and Srinivasu Sunkara, MD, IPA Medical Director.

Omnicare is fiscally sound, offers competitive reimbursement, commitment to attracting and retaining our membership and providing the most up to date information regarding the healthcare industry and how it may impact your practice. Omnicare has remained active in educating and empowering its Primary Care Physicians.

Omnicare is committed to developing healthy relationships by offering quality health care and service through its spectrum of products.

We are currently contracted with the following Health Plans:

- **Blue Cross of California** Medi-Cal, Commercial
- **Blue Shield of California** Commercial, including PPO/POS, and Medicare Advantage
- **Blue Shield Promise** Medi-Cal
- **Central Health Plan** Medicare Advantage
- **Health Net of California** Commercial, including POS/PPO, Medicare Advantage, Medi-Cal, Covered California
- **LA Care Health Plan** Medi-Cal, Covered California
- **Molina Healthcare** Medi-Cal
- **United HealthCare** Commercial, including POS/PPO

Chapter 2

Provider Network Services

Omnicare – Provider Network Services

Omnicare Provider Network Administrators: Here to Support You

At Omnicare Medical Group, our Provider Network Administrators (PNA) serve as dedicated liaisons to support you every step of the way. From the moment you join our network, you'll be assigned a dedicated PNA who will work closely with you to ensure a smooth and positive experience. Their role is to help you navigate our systems, address your needs, and maximize the value of your partnership with Omnicare.

Provider Network Department*

Corey Moffatt	Director, Provider Network Management	cmoffatt@alturamso.com
Melissa Espinales	Executive Assistant	mespinales@alturamso.com
Moises Herreros	Sr Provider Network Administrator	mherreros@alturamso.com
Rocio Sevilla	Sr Provider Network Administrator	rsevilla@alturamso.com

*For phone number and additional information, please see Chapter 10, Contact Information.

Provider Network Administrators offer support such as:

- Provider Site visits
- Training your staff on Omnicare’s policies and procedures
- Providing ongoing education resources such as the provider portal
- Resolving operational issues to improve health care delivery
- Being available to answer your questions
- Access to Omnicare Provider Portal – CONNECT.AlturaMSO.com

If you have any questions or concerns, please contact your assigned Provider Network Administrator or call Melissa Espinales, Administrative Assistant, at (310) 900-4280.

Certified Enrollment Counselor

Available on-site is a Certified Enrollment Counselor (CEC) to assist the public in obtaining health insurance. With management approval, the CEC can come to your office to assist your patients with enrolling or enrollment retention. Please see chapter 10, Contact Information, for CEC contact number.

Omnicare IPA Network Operations: Quality Care Support

At Omnicare Medical Group, the IPA Network Operations Team is dedicated to supporting your practice in providing excellent quality care to your enrolled membership. Upon joining Omnicare, you will be assigned a dedicated Provider Relations Specialist (PRS), Risk Adjustment Program Coordinator, Quality Improvement Specialist and Marketing Specialist.

The Provider Relations Specialist (PRS) will work closely with you on risk adjustment, HEDIS quality, patient experience and value based care performance, adding in improved performance in these areas.

Provider Relations Specialists support offering:

- Provider Site visits
- Cozeva platform access and support
- Engagement with risk adjustment and quality improvement Subject Matter Experts (SME)
- Monthly HEDIS Quality Performance and Gap In Care patient pursuit list review support
- Monthly Annual Wellness Visit (AWV) and Medicare Health Assessment (MHA) summary and outreach list review support
- Collaboration with Marketing for membership growth

Quality Improvement Specialists support offering:

- Distribute and Review Monthly Reports:
 - HEDIS Quality Performance
 - Clinic Analysis
 - Gap In Care patient pursuit lists
- Cozeva platform training and best practices

Risk Adjustment Program Team support offering:

- Distribute and Review Reports:
 - Annual Wellness Visit (AWV) Completion Performance
 - Medicare Health Assessment (MHA) Chart Note Submission via Cozeva
 - Chronic Condition Documentation and Coding Review and Training
- Cozeva platform training and best practices

Marketing Specialists support offering:

- Distribute and Review Reports:
 - Medicare 101 Training for your staff and members
 - Medicare Age-In Member list
 - Community Marketing Support
 - Broker Introduction

Management Company – Altura MSO

Omnicare is supported by a medical management company, Altura MSO, which assists in meeting the needs of both our members and providers. A dedicated Nurse Case Manager is assigned to help coordinate care and ensure timely access to appropriate health care services. Altura MSO's Case Management program promotes proactive health care management by focusing on early assessments to identify members who may benefit from preventive education and intervention.

Altura MSO

Altura MSO Provider Portal Access and Functionality

Omnicare Primary Care Physicians, Specialists, and Ancillary Providers utilize the **Altura MSO Provider Portal**, available at [CONNECT Portal \(alturamso.com\)](https://www.alturamso.com), to perform a variety of essential administrative and clinical tasks.

Through the portal, providers can:

- Submit online referral authorization requests
- Access medical records and documentation
- Conduct provider research
- Check the status of referrals and claims
- Verify member eligibility
- Access key provider reports, including:
 - HEDIS data
 - New Member Lists
 - Actionable P4P Reports

Additionally, the portal serves as a centralized resource for **important documents** that support patient care and help ensure compliance with regulatory and Health Plan requirements. We strongly encourage all providers to become familiar with the portal's features to streamline workflows and enhance coordination of care.

As a contracted Primary Care Physician or Specialist, you will receive a formal orientation conducted by your assigned Provider Relations Representative in collaboration with Altura MSO. During this orientation, you will be issued a personal ID and password to access the Altura MSO Provider Portal.

For step-by-step instructions on how to access and use the portal, please refer to the **Altura Portal User Guide**. The guide is available in the Appendix of this manual or can be downloaded directly from [AlturaMSO.com](https://www.alturamso.com).

We encourage you to review the guide thoroughly to ensure efficient use of the portal and full access to its features.

Chapter 3

Medical Management

Omnicare – Medical Management

Omnicare offers a Case Management Services that is designed to coordinate resources and create appropriate cost-effective options for our patients that require extensive or ongoing services. The case management efforts are focused on the restoration, maintenance, and preventative aspects of self-care.

Case Management

Through our Case Management services, the nurses promote health management of our members by focusing on early assessment for chronic disease and special needs, and by providing education regarding preventive services. In addition to this member focus, the nurses are available to assist our provider network with health care delivery to our members.

Utilization Management

Medical Management, through its utilization management processes, is structured to deliver fair, impartial, and consistent decisions that affect the health care of our members. If there is a utilization denial, you will be provided with written notification and the specific reason for the denial, as well as your appeal rights. In addition Altura MSO or an appropriate practitioner, will be available to discuss any utilization issues and the criteria utilized in making the decision. Utilization decision-making is based solely on appropriateness of care and service and existence of coverage. Please submit necessary supporting documents to prevent a delay or denial of your request. You can reach Altura MSO Utilization Department by calling (855) 848-5252. Medical Management's business hours are 8:00 am to 5:00 pm Monday through Friday. However, we do recommend that you contact your assigned Provider Network Administrator to assist you with any issues.

Referral/Authorizations

Omnicare promotes the traditional primary care relationship between physicians, specialists and their patients. Omnicare recommends that the PCP coordinate the entire episode of care to ensure the timely initiation and appropriate utilization of health services. We do recognize that there are certain situations and circumstances in which the specialist provider would request a referral to another specialist.

The Provider Referral Form is utilized to obtain pre-authorization for services outside of the PCP/Specialist office. The Provider Referral Form is available electronically for completion and submission to Altura MSO. Use of the electronic form is secure and is the preferred method of submitting requests for pre-authorizations. If you cannot submit your authorization electronically, see sample authorization form. Urgent requests for pre-authorization may be made by faxing Medical Management at (323) 720-5608. Medical Management strives to respond to provider requests for pre-authorization of services in an efficient and prompt manner.

Please remember the following when submitting your pre-authorization:

- All Inpatient/outpatient services require Pre-Authorization

- All Out-of-Network services require Pre-Authorization
 - All “not otherwise classified” (NOC), “unlisted”, or “unspecified” codes require clinical review
 - All services/procedures billed to Omnicare/Altura MSO must be both medically necessary and coded appropriately.
-
- Following: See Appendix
 - Altura Authorization Request Form

Chapter 4

Provider Responsibilities

Omnicare – Provider Responsibilities

This section will address several important responsibilities of every Provider. It is important that you adhere to this section to ensure you remain in good standing with us. If you have any questions, please do not hesitate to contact your assigned Provider Network Administrator.

1. Initial Health Appointments (IHA)

The Department of Health Care Services (DHCS) requires primary care physicians (PCPs) to complete an initial health appointment (IHA) for all new Medi-Cal members within 120 days of their Health Plan enrollment date. You have 120 days to call your newly assigned patients in for their Initial Health Assessment. The goal of the IHA is to assess acute, chronic and preventative health needs.

2. Access and Availability Standards and After-Hours Care

All PCPs and Specialists are responsible for offering members access to covered services 24 hours a day, 7 days a week. Access includes regular office hours on weekdays and the availability of a provider or designated agent by telephone after regular office hours, on weekends and on holidays. When unavailable, providers must arrange for on-call coverage by another participating provider. See following pages for sample access and available standards and after-hours care script.

3. Electronic Health Records (EHR)

All PCPs and Specialists will be required to participate in electronic health record (EHR). An EHR is a digital version of a patient's paper chart. EHRs are real time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive of a broader view of a patient's care. EHRs contain a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results. Allow access to evidence-based tools that providers can use to make decisions about a patient's care.

If you have any questions or concerns, please contact your assigned Provider Network Administrator.

4. Laboratory Services

Omnicare utilizes Quest Diagnostic as our provider for laboratory services. It is vital that all lab work is submitted through Quest Diagnostics. Quest Diagnostic will provide you and our members with responsive, convenient, high-quality services. Quest Diagnostic has more than 100 phlebotomy locations. Please contact Omnicare for a list of phlebotomy locations or you may visit the Quest Diagnostic website at www.questdiagnostics.com for locations and hours.

5. Provider Profile Update Reminder

All contracted provider profiles must remain current. If you have recently moved, or changed your telephone or fax number without notifying us, please send the updated information to Altura Contracting via email at contracting@alturamso.com or fax (323) 721-1171, or your assigned Provider Network Administrator. Additionally, please complete and return the Practice Data Validation Form to ensure our records are accurate.

6. Participating Providers

All Participating Providers in your office must be credentialed. If you have a Participating Provider who needs credentialing, please contact your assigned Provider Network Administrator.

7. Non-Contracted Providers - Primary Care Physician

Omnicare works diligently to negotiate contracts in our network. Please refer members to our contracted Specialty and Ancillary Providers. If you have a Specialist or Ancillary Provider you would like us to consider, please email the Contracting Department at Contracting@alturamso.com or fax to (323) 721-1171.

8. Consultation Notes – Specialist

After each office visit with the patient, please provide the patient's primary care physician with a copy of the chart notes. You will find the primary care physician's fax number listed on the referral form.

9. Quality Measure Updates

We encourage all Providers to review their quality measure coding on an annual basis to ensure accurate reporting of the acuity of our patient population. If you are uncertain whether your codes are current, please refer to the Value Set Directory available on the L.A. Care website at www.lacare.org/provides-resources/hedis-resources.

10. Medi-Cal License – Effective January 2019

In an effort to remain compliant with the Department of Health Care Service (DHCS) and our Medi-Cal contracted health plan partners, providers participating in Medi-Cal managed care health plans are now required to actively enroll in the DHCS Medi-Cal program.

Following: See Appendix

- Provider Network Oversight Policy: Access and Availability Standards
- Provider Data Validation Form

Note: This section is not intended to supersede the responsibilities outlined in the Agreement. If you have any questions, please contact your assigned Provider Services Representative.



Chapter 5

Claims

Omnicare – Claims

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, and, where applicable, PPO products where Omnicare Medical Group, Inc. is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

❖ **Billing**

Contracted providers will have 90 calendar days from Date of Service to submit claims. Non-contracted providers shall have 180 calendar days from Date of Service to submit claims.

1. **Claim Submission Instructions**

- A. Sending Claims to Omnicare Medical Group, Inc. Claims for services provided to members assigned to Omnicare Medical Group, Inc. must be sent to the following:

Mail:	Omnicare Medical Group, C/O Altura MSO PO Box 7280, Los Angeles, CA 90022-0980
Physical Delivery:	1401 N Montebello Blvd, Montebello CA 90640
Via Clearinghouse:	Office Ally (909) 464-9129
Omnicare Payer ID:	OMN02

- B. Calling Omnicare Medical Group, Inc. Regarding Claims. For claim filing requirements or status inquiries, you may contact Omnicare Medical Group, Inc. by calling: (855) 855-5252.
- C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by Omnicare Medical Group, Inc.

❖ **Provider Disputes**

A contracted provider dispute is a provider's written notice to Omnicare Medical Group, Inc. and/or the member's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim.

- I. Time Period for Submission of Provider Disputes. Contracted provider disputes must be received by Omnicare Medical Group, Inc. within 365 calendar days from provider's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or

Please refer to your contract, Claims Settlement Practices & Dispute Resolution Mechanism, for complete information in submitting claims and claims settlements.

❖ **Balance Billing**

Per Federal and State regulations, L.A. Care has included prohibitions on balance billing in its provider contracts. Network providers who engage imbalance billing are in breach of their contract with L.A. Care Health Plan. Providers who engage in balance billing may be subject to sanctions by L.A. Care, CMS, DHCS and other industry regulators. Contracted Providers cannot balance bill a Medi-Cal and or Medicare eligible beneficiary for any covered benefit. See following pages for balance billing information.

Note: This section is not intended to supersede the responsibilities outlined in the Agreement. If you have any questions, please contact your assigned Provider Network Administrator

Chapter 6

Member Rights

Omnicare – Member Rights

Omnicare members have the right to, but not limited to, the following:

- Be treated with respect and dignity.
- Personal privacy
- Participate with practitioners in decision-making regarding your health care.
- Candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about Omnicare or the care provided.
- Request translation services, interpretative and/or auxiliary aide services (for the sensory impaired) at no cost, to ensure that you have an equal opportunity to access and participate in all services. You have the right to a certified medical interpreter or sign language interpreter to translate health information accurately, who must respect your privacy and keep all information confidential.

This section only represents a small portion, but significant, outline of Member's Rights. We look to our contracted Providers to follow the requirements to ensure patients are treated respectfully and according to Health Plan guidelines.

Chapter 7

Urgent Care

Omnicare – Urgent Care Locations

Omnicare Medical Group members have access to urgent care centers located in Los Angeles and surrounding areas. As an alternative to visiting the emergency room, which may result in long waits and high out-of-pocket costs, urgent care centers can treat our members with non-life-threatening conditions in these well-equipped facilities and advanced technology. Here is a list of our contracted urgent care locations. If you would like a copy for your office, please contact your assigned Provider Network Administrator or call Omnicare at (310) 900-4280.

DUSK TO DAWN URGENT CARE

15745 PARAMOUNT BLVD	PARAMOUNT	CA	90723-4332	(562) 808-2273
701 E 28TH STREET STE 401	LONG BEACH	CA	90806-2743	(562) 426-2661
709 NEWMARK MALL	MONTEBELLO	CA	90640	(323) 888-2273
1045 W REDONDO BEACH BL ST 138	GARDENA	CA	90247-4104	(310) 323-2273
323 N PRAIRIE AVE STE 434	INGLEWOOD	CA	90301	(310) 673-2273
3356 W BALL ROAD STE 120	ANAHEIM	CA	92804	(714) 828-2213

MINUTECLINIC

5623 KANAN RD	AGOURA	CA	91301-3358	(866) 389-2727
1401 S BALDWIN AVE	ARCADIA	CA	91007-7922	(866) 389-2727
511 N HOLLYWOOD WAY	BURBANK	CA	91505-3406	(866) 389-2727
10889 WELLWORTH AVE	LOS ANGELES	CA	90024-4918	(866) 389-2727
2900 N SEPULVEDA BLVD	MANHATTAN BEACH	CA	90266-2730	(866) 389-2727
13171 MINDANAO WAY	MARINA DEL REY	CA	90292-6307	(866) 389-2727
775 E FOOTHILL BLVD	POMONA	CA	91767-1223	(866) 389-2727
19353 VICTORY BLVD	RESEDA	CA	91335-6302	(866) 389-2727
25880 MCBEAN PKWY	SANTA CLARITA	CA	91355-2004	(866) 389-2727
2505 SANTA MONICA BLVD	SANTA MONICA	CA	90404-2011	(866) 389-2727
14735 VENTURA BLVD	SHERMAN OAKS	CA	91403-3673	(866) 389-2727
2791 AGOURA RD	THOUSAND OAKS	CA	91361-3101	(866) 389-2727
4235 PACIFIC COAST HWY	TORRANCE	CA	90505-5525	(866) 389-2727
8491 SANTA MONICA BLVD	WEST HOLLYWOOD	CA	90069-4218	(866) 389-2727



ORTHOPEDIC INSTITUTE FOR CHILDREN

403 WEST ADAMS BLVD	LOS ANGELES	CA	90007-2664	(213) 742-1104
---------------------	-------------	----	------------	----------------

WILINGTON URGENT CARE

714 N Avalon Blvd	WILINGTON	CA	90744	(310) 522-4200
-------------------	-----------	----	-------	----------------

BAYSIDE MEDICAL CENTER- URGENT CARE

2301 W El Segundo Blvd	Hawthorne	CA	90250	(323) 757-2118
------------------------	-----------	----	-------	----------------

VERNON URGENT CARE

231 W Vernon Ave #112	Los Angeles	CA	90037	323) 234-1468
-----------------------	-------------	----	-------	---------------

TWEEDY URGENT CARE

3314 Firestone Blvd	South Gate	CA	90280	(323) 537-8484
---------------------	------------	----	-------	----------------

We will modify this section routinely. Your assigned Provider Services Representative will provide you will an updated list as it becomes available.

Chapter 8

Cultural Linguistics

Interpreting Services

Healthcare Providers are required to provide **free** language assistance to limited English Proficient (LEP) and hard of hearing or deaf persons in their office. If a member requires or request interpreting services, please contact the member’s health plan listed below. Additional information is available on the Altura CONNECT Portal.

**LANGUAGE ASSISTANCE PROGRAM
INTERPRETIVE SERVICES
BY HEALTH PLAN**

BLUE CROSS OF CALIFORNIA	1-888-285-7801
BLUE SHIELD OF CALIFORNIA	1-800-541-6652
CENTRAL HEALTH PLAN	1-866-314-2427
HEALTH NET OF CALIFORNIA:	
COMMERCIAL	1-800-522-0088
COVERED CALIFORNIA/HEALTH NET DIRECT	1-888-926-2164
MEDI-CAL	1-800-675-6110
MEDICARE	1-800-275-4737
LA CARE	1-888-839-9909
MOLINA HEALTH CARE	1-888-665-4621
UNITED HEALTH CARE	1-877-842-3210

Chapter 9

Trainings

Through the year, you will be required to participate in on training sessions, presented by the Health Plan or Omnicare. After each session, you will need to sign an attestation form completing your training. The attestation form will be placed in your file to attest your completion of the training.

Training(s): See Appendix

1. Balance Billing
2. Fraud, Waste and Abuse
3. Palliative Care Guidelines for Coordination and Referral

Chapter 10

Contact Information

Omnicare Medical Group 1401 N. Montebello Blvd, Montebello, CA 90640 310-605-0000

LEADERSHIP			
President	Cristian Rico, MD	crrico@altamed.org	323-622-2420
Vice President, IPA Network Operations	Rashi Hemnani	rhemnani@altamed.org	323-695-5752
IPA Medical Director	Srinivasu Sunkara, MD PhD	vsunkara@altamed.org	858-342-1892
UM Medical Director	Ashok Raheja, MD	araheja@alturamso.com	310-887-0768
IPA NETWORK OPERATIONS			
Director, IPA Network Operations	Marlo Afflalo	maafflalo@altamed.org	323-895-2240
Associate Director, Quality Improvement	Charleen Mikail, MPH, CHES	cmikail@altamed.org	626-660-8083
Manager, IPA Network Operations & Special Projects	Jose Jimenez, Jr	jjimenezjr@altamed.org	323-480-0584
Provider Relations Specialist	Rosanna Perez	rosanperez@altamed.org	323-695-7546
Provider Relations Specialist	Orlando Gonzalez	orlgonzalez@altamed.org	323-895-2865
Provider Relations Specialist	Alejandro "Alex" Utria	alutria@altamed.org	323-427-8051
ALTURA MSO - PROVIDER NETWORK MANAGEMENT			
Vice President, Provider Network Management	Mark Martinez	mmartinez4@alturamso.com	424-997-7104
Director, Provider Network Management	Corey Moffatt	cmoffatt@omnicaremedgroup.com ; cmoffatt@alturamso.com	310-900-4280
Sr. Provider Network Administrator (PNA)	Moises Herreros, Sr.	mherreros@alturamso.com	323-889-7331
Sr. Provider Network Administrator (PNA)	Rocio Sevilla	rsevilla@omnicaremedgroup.com; rsevilla@alturamso.com	310-900-4290
Executive Assistant	Melissa Espinales	mespinales@alturamso.com	310-877-0665
ALTURA MSO - MEDICAL MANAGEMENT			
Vice President, Medical Management	Bonnie Orellana, RN	boorellana@alturamso.com	323-597-2956
Director, Medical Management Operations	Laura Larios	lyoung@alturamso.com	323-417-7741 ext. 6090
Director, Utilization Management - Inpatient Inpatient Department Leadership	Wanda Jackson, RN	wjackson@alturamso.com DL_INPT_Supervisor@alturamso.com	323-695-6388
Director, Utilization Management - Outpatient Prior Auth Department Leadership	Nichole Loza, LVN	nloza@alturamso.com DL_UMSupervisors@alturamso.com	323-303-2192
Director, Case Management Case Management Department Leadership	Heather Keeler, RN	hkeeler@alturamso.com CMLEADERS@alturamso.com	323-597-2964
Director, Quality Management Quality Department Leadership	Mastoor Khwajazada, FMG, RCP, MHA	mkhwajazada@alturamso.com DL_qualitymanagementdepartment@alturamso.com	424-997-7079
ALTURA MSO - QUALITY MANAGEMENT DEPARTMENT			
Grievance and Appeals Manager	Yolanda Booze	ybooze@alturamso.com	
C&L-Health Education Bussiness analyst	Elaine Woo	elwoo@alturamso.com	
Quality Improvement Specialist	Anadeiry Martinez	anadmartinez@alturamso.com	
Quality Improvement Specialist	Irene Granados	igranados@alturamso.com	
Quality Improvement Coordinator	Erlinda Sorto	ersorto@alturamso.com	
Quality Improvement Coordinator	Mya Gonzales	myagonzalez@alturamso.com	
ALTURA MSO - RISK ADJUSTMENT PROGRAM			
Director, Risk Adjustment Program	Soraya Toubal	stoubal@alturamso.com	323-201-9795 ext. 7824056
Risk Adjustment Program Inquiries related to: HCC, AWV, MHA, RAF or incentives, contact:		RAP@alturamso.com	
MARKETING			
Vice President, Sales Senior Programs	Hector Lazaro	hlazaro@AltaMed.org	323-278-4213
Director, Marketing and Sales Programs	Mozell Bostwick	MBostwick@AltaMed.org	323-832-0242
Manager, Marketing & Business Development	Maribel Nevarez	Mnevarez@altamed.org	323-278-4226
Marketing Specialist, II	Alex Torres	atorres@altamed.org	323-243-9940



Appendix

ALTURA AUTHORIZATION REQUEST FORM

URGENT (72 HOURS) Requests submitted as an urgent referral when standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.

ROUTINE (5 BUSINESS DAYS/*14 CALENDAR DAYS)
 Medi-Cal Commercial Cal MediConnect *Medicare

RETRO (30 CALENDAR DAYS) Request must be submitted within 30 calendar days from service date

For Inquiries or questions on authorization status or in general call the Altura Customer Service Department at: (855) 848-5252.

Continuity of Care Standing Referral Second Opinion

SUBMIT AUTHORIZATION REQUEST VIA FAX TO (323)720-5608

REQUEST DATE: _____

PATIENT INFORMATION

Patient's Name: _____ **DOB:** _____

Health Plan: _____ **Health Plan ID:** _____

AUTHORIZATION REQUEST INFORMATION

DIAGNOSIS: _____ **ICD-10:** _____

REFERRED TO PROVIDER: _____

ADDRESS/Telephone: _____

NPI/TAX ID: _____

REASON FOR REFERRAL: _____

CPT Code: _____ **CPT Description:** _____

TREATMENT AND WORK-UP DONE WITH RESULTS: _____

ATTACHMENTS:

Clinicals Laboratory & Radiology Findings Medication List Other

 (Requesting Provider Signature) (Print Physician's Name)

Requesting Provider Address: _____

Requesting Provider Phone: _____ **Requesting Provider Fax:** _____

Office Contact Name/Telephone: _____

Primary Care Physician (If different than referring Provider): _____

INTERNAL USE ONLY: _____



Policy Title: Provider Network Oversight
Policy No.: PO-ALL-001-2021
Issuing Dept.: Provider Oversight
Applicable To: M-Cal Comm Medicare
Effective Date: 07/01/2020
Last Review Date: 02/16/2024

Policy and Procedure

Purpose

The Risk Bearing Organization (RBO) establish an oversight framework to monitor C/O Altura MSO clients, provider network compliance with operational, Health Plan, and regulatory requirements.

Policy

1. Altura’s Provider Oversight (PO) department is responsible for developing and deploying ongoing monitoring of all practitioner Access to Care for all for Primary Care Physicians (PCP), Non-Physician Behavioral Health Providers, Specialty, and Ancillary providers as well as monitoring to ensure compliance with operational, health plan, and regulatory requirements.
 - 1.1 Any identified Quality of Care issues as a result of Access to Care will be reported to the Quality Department to help address any clinical concerns in collaboration with our oversight efforts.
2. The Provider Oversight Team adopts DMHC's standardized guidelines and the develop methodology (Survey Tools and Reporting Templates) requirements to assess the timeframe for the provider's next available appointment to measure Timely Access compliance as well as After-Hours. In accordance with DMHC Health and Safety Code section 1367.03, subsection (i).
3. Altura’s client Medical Officer, AVP of Provider Network Management (PNM), and the designated Compliance Department, may sanction and/or terminate providers to due to the repeated or serve non-compliance.
4. The following elements will be considered by the AVP when prioritizing interventions and focused areas:
 - 4.1 Particular performance measure (s).
 - 4.2 Volume of assigned patients or membership.
 - 4.3 Regulatory or health plan changes and/or priorities.
 - 4.4 Network of provider compliance trends or history.
 - 4.5 Network adequacy.
5. All client’s sites and provider types are expected to, as a condition of participation in Altura’s network required to be available to ensure an appointment within a specific number of days.



6. CMS requires the Risk Bearing Organization (RBO) C/O Altura MSO deploy written standards for timeliness of access to care. These standards must ensure that the hours of operation for Altura’s clients are convenient to, and do not discriminate against Member and are no less available than hours offered to other patients and that services are available 24/7, when Medically Necessary. See Medicare Managed Care Manual (MMCM), Chapter 4, Section 110.1.1.

7. Enrollees must be offered appointments within the following timeframes:
 - 7.1 Urgent Care appointment for services that do not require prior authorization- within forty-eight (48) hours after request.
 - 7.2 Urgent appointment for services that do not require prior authorization within ninety-six (96) hours after request.
 - 7.3 Non-urgent primary care appointments-within ten (10) business days after request.
 - 7.4 Appointment with a specialist- within fifteen (15) business days after request.
 - 7.5 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition- within fifteen (15) business days.

Procedure

1. **Access To Care Standards** - All applicable Altura clients must meet the access standards delineated below.

The following information delineates the access standards for appointment availability of services to Members including primary care, specialty care, after hours, emergency services, waiting times for appointments.

1.1 Appointment Standards:

Primary Care Physician	
Type of Visit	Timeframe
Urgent Visit	Forty-eight (48) hours
Routine non-urgent visit	Within ten (10) business days of request
Routine Preventative appointment	Thirty (30) Business Days
Initial Prenatal Visit	Within (10) business days
Services Not Emergent or Urgently Needed but Requires Medical Attention (Medicare LOB)	Within seven (7) business days
Specialist	
Type of Visit	Timeframe
Urgent Visit, requiring authorization	Ninety-six (96) hours
Non-urgent appointments with Specialist Physician	Within fifteen (15) business days of request



Non-urgent ancillary services (for diagnosis and treatment)	Within fifteen (15) business days of request
Initial Prenatal Visit	Within (10) business days
Behavioral Health	
Urgent Care Appointment	Forty-eight (48) hours
Non-urgent follow up appointment.	Within ten (10) business days of request
Routine mental health appointment (non-physician)	Within ten (10) business days
Urgent Care	
Prior authorization not required by health plan	2 days
Prior authorization required by health plan	4 days

2. **Business Hours Telephone** - All telephone calls to a PCP or Specialist must be answered within 30 seconds.
3. **Non-urgent Specialist Appointment** – These are referrals to a health care professional who has advanced education and training in a specific area. The appointment to the Specialist is to be scheduled within fifteen (15) days of request unless otherwise indicated by the referring Physician.
4. **After Hours PCP and Specialist Access** – Altura’s clients provides Members with twenty-four (24) hours; seven (7) days a week direct access to a telephone triage or screening services, providers must ensure recording answering service notifying the member that the provider is available on call for after hour for urgent matters.
5. **Emergency Instructions**- Providers are expected to have coverage after hour’s staff, answering service and/ or answering machine directing the callers to dial 911 or go to the nearest emergency room.
6. Provide (or arrange for) telephone triage or screening services on a 24/7 days basis with wait times not to exceed 30 minutes. Patients can get help to determine how urgent their condition is, including a return call within a reasonable timeframe, not to exceed 30minutes.

Implementation Monitoring Plan

1. The Provider Oversight Team assesses Altura MSO clients annually for access standards of PCPs, Specialists, and Ancillary Providers using the Department of Managed Health Care (DMHC) Provider Appointment Availability Survey Methodology.



2. Methodology includes the use of the DMHC Provider Appointment Availability Survey for PCPs, Specialty Care Physicians and Non-Physician Mental Health Providers. The Provider Oversight team monitors office wait times by collecting wait time information during the Provider in- service to confirm compliance with access standards.
3. The annual assessment is conducted to monitor the network for Providers that are not meeting access standards in order to take action to bring the Providers into compliance for all PCP and Specialist while establishing performance indicators, targets and thresholds for all providers.
4. Altura MSO clients will follow the sampling methodology as outlined by the DMHC for all providers. Altura MSO will separately report a rate of compliance for each of the time elapsed standards for each provider located in each county of Altura's clients service area annually using the DMHC Provider Appointment Availability Survey Methodology and the DMHC Provider Appointment Availability Survey tools for PCPs, Non-Physician Behavioral Health Providers, Specialty and Ancillary Care Providers while collaborating with other businesses partners to manage network compliance and will report monitoring outcomes and action plans. (See, "DMHC Provider Appointment Availability Survey Methodology" and "DMHC Appointment Availability Survey Tools in Section 9).
5. Altura MSO may utilize a 3rd party survey vendor to implement all or part of the DMHC Provider appointment Availability Survey methodology.

Corrective Action Plan

1. Performance below established compliance thresholds, whether monitored by Altura MSO, regulations, or health plans, will trigger the following response within the same audit period:
 - 1.1 Provider Oversight shall monitor the resolution for a predetermined timeframe for example, 60 days to ensure ongoing compliance with regulating standards.
 - 1.2 Initial non-compliance: Warning notice to provider requesting improvement and advising the provider of potential additional monitoring.
 - 1.3 Second non-compliance of the same issue or concern: Formal request for corrective action plan with follow-up monitoring within 30 days; non-compliance entry noted in the credentialing file.
 - 1.4 Third non-compliance of the same issue or concern: escalation of continued non- compliance to leadership for sanction, termination of affiliation, or other action(s) commensurate to the issue.
 - 1.5 Please note that, due to the severity of the issue or concern, Altura MSO may elect to skip response levels, particularly if non-compliance impacts patient safety or quality.

References and Citations

1. https://www.dmhc.ca.gov/Portals/0/Docs/DO/TAC_accessible.pdf -Timely Access to Care Educational Guidelines.
2. <https://www.dmhc.ca.gov/Portals/0/Docs/OPM/2019kkaregs.pdf#page=270> -Section 1367.03 of the California Health and Safety Code.
3. <https://www.dmhc.ca.gov/Portals/0/Docs/OPM/2019kkaregs.pdf#page=701> - Section 1300.67.2.2 in Title 28 of the California Code of Regulations.
4. [https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/ta2nehcs.pdf- 1300.67.2.2](https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/ta2nehcs.pdf-1300.67.2.2) - §1300.67.2.2 Timely Access to Non-Emergency Health Care Services
5. Title III of the Americans with Disabilities Act of 1990.
6. Final Rule (Mega Reg) is 81 FR 27497 and codified as 42 CFR Part 438 and Department of Health Care Services (DHCS) All Plan Letter (APL) 19-002 supersedes APL 18-005, “Network Certification Requirements” Attachment A.
7. Medicare Managed Care Manual, Chapter 4, section, 110.1.1

Company/Client Approval(s)

Date	Company/Client	Approve By (Full Name – Title)
07/20/2021	Altura MSO	Steven Chin, AVP Provider Network Management
7/20/2021	AltaMed Health Services	AltaMed
7/20/2021	Omnicare Health Services	Omnicare
09/01/2023	LaSalle Medical Associates	LaSalle Medical Associates

Version History

Date	Company/Client	Action Description

PRACTICE DEMOGRAPHIC VALIDATION

In an effort to remain compliant with Senate Bill 137, we are collectively responsible for maintaining current and accurate information of our provider network. Please complete all sections below and enter N/A for any non-applicable fields. Altura will review to ensure any updated information is reflected in our database and relayed to our contracted health plans accordingly.

Any future demographic updates may be submitted to your Provider Network Administrator or to Contracting@alturamso.com.

Please attach the following items along with this form:

- Updated W-9
- Updated Provider Roster

PRACTITIONER INFORMATION

Contract Entity Name _____		<input type="checkbox"/> FQHC	Group NPI _____
Billing Address _____	Contracting Contact Name _____		Contracting Email _____
Contracting Contact Name _____		Billing TIN _____	
Credentiaing Contact Name _____		Credentiaing Email _____	
Provider Class	<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Mid-level	Hospital-based	<input type="checkbox"/> Yes <input type="checkbox"/> No
Practitioner Name _____		Individual NPI Number _____	
<small>(Last, First, Professional Title)</small>			
CA License Number	_____	Practitioner Email	_____
Primary Specialty	_____	Secondary Specialty	_____
Supervising Physician	_____	Age Restrictions	_____
<small>(applies to mid-levels only)</small>			
Telehealth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Line(s) of Business	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare
EMR	<input type="checkbox"/> Yes <input type="checkbox"/> No EMR Vendor _____	<input type="checkbox"/> Commercial	

FACILITY PRIVILEGES

Surgery Center (ASC) _____

Hospital _____

Physical Location(s) as it will appear in the directory

(If a PCP, physical locations need to have passed a current Facility Site Review)

	Address	Phone	Fax	Office Hours	After Hours No.
Site 1	_____	_____	_____	_____	_____
Site 2	_____	_____	_____	_____	_____
Site 3	_____	_____	_____	_____	_____
Site 4	_____	_____	_____	_____	_____

Print Name _____ Date _____

Authorized Signature _____



Provider Network Administrator (PNA) _____

PNA Signature _____

The Facts on Balance Billing

What is balance billing?

Dual eligible beneficiaries (“Medi-Medis”) are individuals with both Medicare and Medi-Cal. Medicare providers (like doctors and hospitals) cannot bill dual eligible beneficiaries for Medicare cost sharing. **This is known as balance billing, or “improper billing,” and is illegal under both federal and state law.** This means dual eligible beneficiaries cannot be charged for co-pays, co-insurance, or deductibles. Similarly, this protection also applies to Qualified Medicare Beneficiaries (QMBs).

Dual eligible beneficiaries or QMBs should never receive a bill for Medicare cost sharing. These beneficiaries should not pay for physician visits and other medical care when they receive Medicare-covered services. For beneficiaries in a Medicare Advantage plan, including a Medi-Medi Plan, beneficiaries should not pay for medical care when they receive covered services from a provider in their provider network. This applies to both Medicare and Medi-Cal providers. **Even if a Medicare provider is not enrolled in Medi-Cal, the provider may not bill the dual eligible beneficiary.**



How should providers bill for Medicare-covered services?

Generally, Medicare will pay 80 percent of the Medicare fee schedule. Medi-Cal is responsible for any Medicare cost sharing, with payment limited to Medi-Cal reimbursement rates. This is known as a “crossover claim.” For beneficiaries in Original Medicare, the Medicare Administrative Contractor processes the primary claim for Medicare payment and then forwards the claim to the Medi-Cal plan for the secondary Medi-Cal payment. For beneficiaries in Medicare Advantage (MA) plans, physicians should bill the MA plan for the primary Medicare payment, and bill the Medi-Cal plan for the secondary Medi-Cal payment. **Providers do not need to be part of the Medi-Cal plan’s network to have these crossover claims processed and paid.** Providers can refer to the [Crossover Billing Provider Toolkit](#) for additional information.

What are the exceptions?

Dual eligible beneficiaries may receive a bill for medical services if they have a:

1. Co-pay for Part D prescription drugs;
2. Monthly share of cost for unmet Medi-Cal costs; and/or
3. Service not covered by Medicare or Medi-Cal.



The Facts on Balance Billing

What should a dual eligible beneficiary do if billed by a health care provider?

If a health care provider has billed a dual eligible beneficiary for a Medi-Cal or Medicare covered service, **the beneficiary should not pay the bill.** Instead, the beneficiary should first try to resolve the issue with their health care provider, to tell them they should not have been billed because they receive both Medicare and Medi-Cal.

Providers must take immediate actions to fix the issue once they know that a beneficiary is dually eligible. The provider must refund any amounts already paid, stop the bill collection process, and work with credit reporting agencies to correct any issues caused by billing dual eligible beneficiaries. Providers can refer to the [Centers for Medicare & Medicaid Services \(CMS\) Medicare Learning Network \(MLN\) Matters Article](#) for additional information.

If the provider does not stop the bill collection process, then the dual eligible beneficiary should contact their MA health plan immediately to resolve the issue or contact 1-800-MEDICARE (1-800-633-4227) if they are enrolled in Original Medicare.

If neither the provider nor health plan resolve the issue, then a dual eligible beneficiary can contact the Medicare Medi-Cal Ombudsman at 1-855-501-3077 to ask questions about what actions to take next or contact the California Department of Managed Health Care Help Center at 1-888-466-2219 to file a complaint.

Types of Dual Eligible Beneficiaries

Full Duals

“Full dual eligibility” means that someone is eligible for both Medicare and Medi-Cal. To have full dual eligibility, it means you qualify for full state Medi-Cal benefits as well as for Medicare. A person who qualifies for full dual eligibility may also qualify for a Dual Special Needs Plan (D-SNP). This is a type of Medicare Advantage plan that offers extra benefits beyond traditional Medicare and Medicaid.

Medicare pays for most of the covered care and benefits, but Medi-Cal pays some out-of-pocket costs for copays, coinsurance, deductibles and premiums. Medi-Cal also covers benefits that aren’t covered by a Dual Special Needs Plan, such as long-term care.

Partial Duals

“Partial dual eligibility” means a person qualifies for a Medicare Savings Program (MSP) but is not enrolled in Medi-Cal. MSPs are managed by the Medicaid program in each state. While MSPs cover certain Medicare costs, like Medicare Part A and Part B premiums, people with partial dual eligibility don’t receive full Medicaid medical benefits.

Additional Resources

- » [California Welfare and Institutions Code Section 14019.4.](#)
- » [Section 1902\(n\)\(3\)\(B\) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997.](#)



**Combating Medicare Parts C & D Fraud, Waste & Abuse
Platform: Medicare Learning Network (MLN)**

<https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN3995723-MLNPartsCD/FWA/story.html>

The banner features a background image of three people in a professional setting looking at a laptop. In the top left corner, there is a logo with colorful circles and the text "mln Web-Based Training Course". A blue box in the center contains the text "Combating Medicare Parts C & D Fraud, Waste & Abuse" and "Select anywhere to continue". In the bottom left corner, there are logos for "CMS" (Center for Medicare & Medicaid Services) and the "Medicare Learning Network".



MEMORANDUM

To: Primary Care Providers and Specialists
Date: 06/25/25
Subject: Palliative Care Guidelines for Coordination and Referral

Dear Colleagues,

As part of our commitment to providing comprehensive, patient-centered care, we are issuing updated guidelines to enhance collaboration between Primary Care Providers (PCPs), Specialists, and the Palliative Care team. These guidelines aim to support timely, appropriate referrals and integration of palliative care services.

Purpose of Palliative Care

Palliative care is a specialized medical approach focused on improving the quality of life for patients with serious or life-limiting illnesses. It addresses physical, emotional, spiritual, and psychosocial needs, alongside curative or life-prolonging treatments.

Key Guidelines for PCPs and Specialists

1. Identification and Referral Criteria

- Refer patients with advanced chronic illnesses, such as:
 - Advanced cancer
 - End-stage organ failure (e.g., CHF, COPD, ESRD)
 - Progressive neurodegenerative diseases (e.g., ALS, dementia)
- Consider referral if a patient exhibits:
 - Poor or declining functional status (e.g., PPS \leq 60)
 - Frequent hospitalizations or ED visits
 - Difficult-to-control symptoms (pain, dyspnea, delirium, etc.)
 - Complex care planning needs or goals-of-care discussions

2. When to Involve Palliative Care

- At time of diagnosis (especially for high-risk or serious illness)
 - During or after a hospital admission for complications or progression
 - When initiating or discontinuing disease-modifying treatment
 - At patient or family request
-

3. Communication & Coordination

- PCPs should maintain ongoing communication with palliative care to ensure continuity.
- Specialists are encouraged to consult with the Palliative Care team early in the treatment plan to align goals and manage complex symptoms.
- Document palliative care discussions clearly in the EHR.

4. Advance Care Planning

- Ensure patients have an updated:
 - Advance Directive
 - POLST/MOLST form, where applicable
 - Documented goals-of-care discussions
- Discuss and document code status, especially during transitions of care.

Referral Process

- Use the Altura Provider Portal to place a consult under "Palliative Care".

Thank you for your commitment to delivering compassionate and coordinated care. Your collaboration is essential in ensuring patients and families receive the support they need throughout their illness trajectory.

Please reach out to the Palliative Care Service at [insert contact info] with any questions or consultation needs.

Sincerely,
Corey Moffatt
Director of Provider Network- Altura