

## **San Luis Obispo California Children's Services CenCal Health Protocols**

### **Overview**

In the County of San Luis Obispo, the San Luis Obispo County Public Health Department and dedicated staff oversee the California Children's Services (CCS) program. CCS is a part of the State Department of Health Care Services (DHCS) and is a program dedicated to the medical care of children with special needs. In general, CCS covers medical conditions that are physically disabling or diseases requiring medical, surgical, or rehabilitative services. Examples of CCS-eligible medical conditions include, but are not limited to, cystic fibrosis, sickle cell disease, hemophilia, cerebral palsy, heart disease, cancer, and traumatic injuries.

At the State level, CCS is responsible for paneling providers who render care to children in San Luis Obispo County with eligible CCS conditions and who meet CCS income guidelines. CCS staff work closely with CenCal Health to assure members who meet certain criteria receive care. Approximately 80 percent of CCS members in the State of California are Medi-Cal eligible. For these clients, the Medi-Cal program reimburses services authorized by CCS.

### **Program and Eligibility**

The CCS program delivers specialized services to financially and medically eligible children under the age of twenty-one (21) years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations. The CCS program provides this medical case management and financial assistance to eligible children. Services offered include diagnostic exams, medical treatment, and physical and occupational therapies. Services unrelated to the CCS condition are covered and available to members of San Luis Obispo Health Initiative (SLOHI), Healthy Kids (HK), or Healthy Families (HF) through CenCal Health.

If a provider suspects that a child has a CCS eligible condition, he/she should contact the member's PCP and inform them of such suspicion. The member's Primary Care Physician (PCP) will then contact the local CCS program and arrange for an evaluation to determine if the child does qualify for coverage by CCS. Members who are eligible with CCS are assigned a Primary Care Provider (PCP). Typically, the member is assigned to the PCP to which CCS has authorized primary care, as long as he/she is contracted/paneled with both organizations.

### **Member Services**

New CenCal Health members will receive a "Welcome Packet" which contains the following documents:

- Welcome letter
- Member Handbook/Evidence of Coverage – explanation of the program and benefits
- Provider Directory – list of Primary Care Physicians and specialists
- Member identification card
- Member newsletter and other health information materials

The Member Services Representatives are bilingual English/Spanish and can answer questions and assist members with:

- Understanding how the health plan works
- Understanding their benefits and Member Handbook/Evidence of Coverage
- Replacing their health plan identification card
- Choosing or changing their Primary Care Physician
- Finding a specialist
- Obtaining information about prenatal and well child care
- Arranging interpreter and American Sign Language services (only for non CCS conditions)
- Filing a complaint or appeal

A member can file a complaint or appeal by calling a Member Services Representative or by submitting their complaint in writing to the health plan. If a member wants to file their complaint in writing, the forms are available through the CenCal Health website at [www.cencalhealth.org](http://www.cencalhealth.org) or at their primary care physician's office. A Member Services Representative can assist a member in filing a complaint or appeal and can also assist the member with accessing care and/or changing their Primary Care Physician.

The Member Services Department has a toll-free number - **1-877-814-1861**; business hours are 8:00am to 5pm, Monday through Friday. The Hearing Impaired should use California Relay Service at 711.

### **CenCal Health Pharmacy Utilization**

#### **How to Use the Formulary**

The formulary is a list of covered agents for CenCal Health's SLOHI, Healthy Kids (HK) and Healthy Families (HF), programs in San Luis Obispo County. All drugs are

listed by their generic names and by one of the proprietary (branded) names. The brand name drugs listed are for reference use only and do not denote coverage. CenCal Health's formulary requires, unless otherwise stated, that Food and Drug Administration (FDA) approved generic drugs are to be used in all situations regardless of the brand name indicated in this formulary.

In addition to prescription drugs the CenCal Health formulary includes selected “Over The Counter” (OTC) items as a covered benefit. As required by law, a written prescription must be obtained from the prescriber for these selected OTC items for them to be a covered benefit.

Any drug not found in this formulary listing, or in any subsequent formulary update published by CenCal Health, shall be considered a non-formulary drug. Coverage for non-formulary drugs may be requested by the prescriber in advance by completing and faxing a Medical Request Form (MRF) to (805) 685-7781. Information may also be requested by contacting MedImpact (CenCal Health’s contractor for pharmacy benefit management services) at **1- 800-788-2949**.

### **Medical Request Form (MRF) Process**

CenCal Health contracts with a Pharmacy Benefit Manager (PBM), MedImpact Healthcare Systems (MedImpact), to assist in the administration of the pharmacy management program including prior authorization requests. Every effort is made to process each MRF upon the initial submission.

MRFs are reviewed by MedImpact who will approve, deny, or defer the request for more information. Under the direction of a clinical pharmacist, all MRFs that lack acceptable medical justification for the intended use of the drug will be denied.

For a CCS eligible member, MedImpact will notify the SLO CCS office through a secure e-mail service; Tumbleweed if a MRF is needed.

The CCS Case Manager is responsible for authorization of medically necessary services and provision of medical case management for Medi-Cal beneficiaries enrolled in the CCS program.

If the medications requested are for CCS eligible conditions CenCal Health is not responsible for coverage. The pharmacy should bill EDS State Medi-Cal for payment.

If CCS determines the request is not for a CCS eligible condition a response is sent back to MedImpact through Tumbleweed, a secure e-mail service. MedImpact will review and base their approval or denial on CenCal Health’s Library of Medication Guidelines.

Prescriptions for the following require a MRF:

- All non-formulary medications
- Brand name drugs when an equivalent generic is available except for those drugs listed as exemptions
- Drugs not meeting the Code 1 restriction or Step Therapy criteria
- Drugs exceeding the member age, dosing limit, quantity or duration of treatment dispensing limits.

## **CenCal Health Clinical/Medical Utilization Process**

### **Authorization**

The local CCS program issues providers a unique Service Authorization Request (SAR) number beginning with a prefix “91” or “97” for services authorized by CCS. CenCal Health receives a SAR database from CCS for claim verification purposes. The SAR number must be included on the claim form in the appropriate prior authorization field or be attached to the claim. A claim for a CCS eligible member may receive a reimbursement premium above the CenCal Health contractual rate if the procedure code is identified by DHCS as one that receives the noted increase.

### **Utilization Management (UM)**

CCS eligibility is routinely checked as part of the CenCal Health Utilization Management process. As indicated above, CenCal Health SLOHI or Healthy Families/Healthy Kids members with known or suspected CCS conditions are required to be referred to the local CCS program. Due to this requirement, providers may receive notations on authorization requests returned by CenCal Health UM staff stating, “Refer to CCS”. This notation may appear on requests for SLOHI or HF and HK members with active CCS cases or those with a known or suspected CCS condition in need of referral.

To facilitate this referral process, CenCal Health UM staff can intervene and assist providers in the provision of needed information to the local CCS program. UM staff is also able to assist providers with case coordination in the event of a CCS case denial. A Treatment Authorization Request (TAR) is required for a non-CCS condition if the procedure is one that routinely requires prior authorization.

Please refer to the CenCal Health website [www.cencalhealth.org](http://www.cencalhealth.org) or the State Medi-Cal website [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) for a list of TAR required procedures.

### **Referrals**

A PCP issues a Referral Authorization Form (RAF) in order to refer an assigned member for medically necessary services not generally provided by a PCP. Most assigned members require a RAF when accessing specialty services. CCS case manages CCS eligible members. Because a SAR is issued for CCS eligible conditions, RAFs are not required for CCS Members although the Members are assigned to a SLOHI PCP. Providers should take care in checking eligibility to take note of both the assigned PCP and potential CCS eligibility. In general, reference the ‘When RAFs are Not Required’ list within this Provider Manual or on the CenCal Health website for information on when a RAF is not necessary.

A referral provider or specialist will *not* need a RAF from the member's PCP for a CCS eligible Member. If the service is related to the CCS condition, CCS may potentially require a SAR from CCS. An approved SAR by CCS replaces the need for any treatment authorization (TAR) from CenCal Health and the provider will be reimbursed the CCS premium, if warranted, for the service, provided that the claim meets all of CenCal Health's rules for claim submission and benefit coverage.

### **CenCal Health Claims/Payment Process**

#### **Submittal**

Original claims for CCS eligible children (children with a CCS diagnosis and/or CCS eligible condition) will not be considered for payment by CenCal Health. SLOHI claims will appear as a denial on an Explanation of Benefits (EOB). HFP/HK claims will also appear as a denial on an Explanation of Benefits, but will be forwarded to the SLO CCS office. It is the provider's responsibility to follow-up with CCS.

If CCS denies a claim and/or authorization, the claims submission to CenCal Health requires that the CCS denial letter accompany it or the claim will remain denied.

#### **Internally Processing CCS Eligibility and Claims**

The CenCal Health Information Technology Department will be requesting an electronic file on a daily basis from the San Luis Obispo CCS Office listing Medi-Cal members who are CCS eligible and those who have been eligible within the last 6 months. These members are loaded into the CenCal Health Member System. The data file should contain the member information as follows:

- Member's unique identifier
- Client Index Number
- Social Security Number
- Member name
- Member date of birth
- CCS eligibility start date
- CCS eligibility ending date
- CCS eligible diagnoses, up to three (3)

Information on State Medi-Cal members eligible with CCS will not be available through CenCal Health.

HF and HK program members who are eligible with CCS will also be loaded into the Member Subsystem. The CenCal Health Member Services Department will be requesting a monthly report of these members from SLOHI. These members will be manually entered into the CenCal Health Member Eligibility Screen,

along with the member's CCS diagnoses submitted on the report and CCS starting and ending dates.

**Payment Requirements**

1. If the claim contains a CCS diagnosis and the member is CCS eligible, then the claim is denied and providers must bill the State Medi-Cal Fiscal Intermediary, Electronic Data Services (EDS).
2. If the claim contains a CCS diagnosis and the member does not have CCS eligibility, then the claim is denied for the CCS diagnosis and the provider must bill EDS.
3. If the claim does not contain a CCS diagnosis code and the member is CCS eligible, then the claim is submitted to the CenCal Health Claims Department for review.
  - If the claim is determined to be related to the CCS condition, then the claim is denied and must be billed by the provider to EDS.
  - If the claim is determined to not be related to the CCS condition, then the claim is considered for payment by CenCal Health.
4. If the claim does not contain a CCS diagnosis code and the member is not CCS eligible, then the claim is considered for payment by CenCal Health.