



CenCalHEALTH®
Local. Quality. Healthcare.



2022 Provider Manual

Provider Services (805) 562-1676

Member Services (877) 814-1861

cencalhealth.org

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Section A: Introduction

A1: Welcome to CenCal Health

CenCal Health is a county organized health system that administers health insurance programs for Santa Barbara County and San Luis Obispo County. We provide services to children, low-income families, seniors, and persons with disabilities. CenCal Health’s insurance programs are built on a foundation of comprehensive and coordinated patient-centered care through the collaboration of physicians, care managers, and other healthcare providers. Our aim is to help our members obtain quality healthcare.

CenCal Health recognizes the strength of our programs depends upon strong collaboration and communication with our provider partners and their staff. We look forward to working with each provider and their staff to provide our members with high quality, cost-effective care. CenCal Health is a (COHS) plan that manages programs funded by the State and federal governments, but operates

independently. CenCal Health is governed by a Board of Directors appointed by the San Luis Obispo County and Santa Barbara County Boards of Supervisors, made up of members, providers, business leaders, and local government representatives.

A2: Intent of this Manual

The Provider Manual is intended as a tool that describes operational policies and procedures as a reference guide for CenCal Health's providers and their staff. It contains basic information about how to work with CenCal Health.

CenCal Health uses State policies determined by the Department of Health Care Services (DHCS) to administer Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI). CenCal Health interprets and modifies the policies with the approval of our Board of Directors. This Provider Manual contains policy information for the SBHI and SLOHI programs. DXC Technology Services, LLC maintains the [Medi-Cal Provider Manuals](#) that offer specific guidelines for the State Medi-Cal program.

For additional information on CenCal Health, visit our website at www.cencalhealth.org.

URLs for above hyperlinks:

DHCS Medi-Cal Manual
<https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx>

A3: How to Use the Manual

CenCal Health drafted the manual as a tool to easily search via the Table of Contents page or through our website. Providers can search for particular topics by reviewing any line item or page number in the table of contents and go directly to the section you need. You may also search the Manual by keyword using CTRL + F.

Topics covered in this Manual include, but are not limited to: member eligibility, authorizations, referrals, covered services, services covered by other agencies, care management, cultural and linguistic services, utilization management, quality assurance and improvement, health assessment and screening, member grievances, billing, coordination of benefits, reporting, credentialing, and dispute resolution.

We encourage providers to become familiar with the contents of the Provider Manual and to refer to it frequently. Please contact the Provider Services Department with any suggestions for additions or improvements to this manual at (805) 562-1676.

A4: Overview of CenCal Health Programs

CenCal Health is the publicly-funded Medi-Cal Managed Care Health Plan for Santa Barbara and San Luis Obispo Counties for low-income residents. Once a resident is granted Medi-Cal, they are automatically inscribed (enrolled) into the CenCal Health Plan. New Members receive a Welcome Packet that provides a Member

Handbook also known as an Evidence of Coverage that explains the benefits available to members along with a listing of doctors, specialty providers, hospitals, and pharmacies available to members of CenCal Health.

Medi-Cal ensures that children and adults with limited income and resources can receive physical and behavioral health services at little or no cost.

This low-income program includes:

- Families with children
- Foster care children
- Pregnant women
- Childless adults
- Seniors
- Persons with disabilities

Individuals and families apply for Medi-Cal through their county Department of Social Services and through Covered California. Applications may be completed in person, online, through the mail, or over the phone. Elderly and disabled individuals who receive Supplemental Security Income (SSI) automatically receive Medi-Cal along with their SSI benefit.

Eligibility for Medi-Cal is month-to-month. Medi-Cal recipients must re-certify their eligibility periodically. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Please note that a member's eligibility must be verified before delivery of services and that the CenCal Health identification card alone is not a guarantee of eligibility. Please refer to **Section G: Eligibility Verification and Enrollment** of the Provider Manual for further [eligibility information](#) or verify on CenCal Health's website.

Not all Medi-Cal beneficiaries are CenCal Health members. Those who are not CenCal Health members are eligible under the Medi-Cal Fee-For-Service system (FFS Medi-Cal). Providers seeing these beneficiaries would bill and be reimbursed directly for covered services by Affiliated Computer Services, the state Medi-Cal fiscal intermediary. Any necessary prior authorization for elective services (referred to as an "Authorized Referral Request," formerly known as "Treatment Authorization Request" or "TAR") for Medi-Cal beneficiaries not covered by CenCal Health should be submitted to the Medi-Cal field office, not to CenCal Health.

URLs for above hyperlinks:

CenCal Health Provider Eligibility Resources
www.cencalhealth.org/providers/eligibility/

A5: Glossary of Terms

The [glossary of terms](#) contains definitions of commonly used terms at CenCal Health. The glossary was written to help give people the words and meanings for each acronym.

URLs for above hyperlinks: Explore CenCal Health's Glossary of Terms

www.cencalhealth.org/explore-cencal-health/glossary-of-terms/

A6: Provider Bulletin

The [Provider Bulletin](#) is a monthly publication that provides information on changes to the Medi-Cal program, new programs, benefit changes, claims information, clinical updates, educational opportunities, and more. This monthly newsletter contains information useful to front office, back office, and medical personnel. It is available to all contracted providers in paper via the US Mail, as well as digitally via email and online.

Individual provider staff can sign up to receive an electronic newsletter via email by signing up through the registration form.

Non-Contracted providers do not receive the monthly US mailed publication, however do have the ability to sign-up for the electronic newsletter via email.

URLs for above hyperlinks:

Provider Bulletin Library

<https://www.cencalhealth.org/providers/provider-bulletin/>

A7: CenCal Health Mission, Vision, and Values

Mission: To improve the health and well-being of the communities we serve by providing access to high quality health services, along with education and outreach, for our membership.

Vision: To be a nationally recognized model for publicly sponsored health care plans, facilitating excellence in care, service and efficiency, and be valued as a community resource.

Values

- Integrity in all of our actions
- Respect and compassion for our members
- Continuous pursuit of performance excellence
- Collaboration with our provider partners
- Responsible stewardship of resources
- Commitment to the community
- Importance of skilled and dedicated staff
- Adaptability to a changing environment

A8: CenCal Health Strategic Priorities

CenCal Health's strategic vision is to grow and expand our membership by serving new populations, improving our services, and remaining responsive to local needs. We believe that we can do so by focusing on the following areas:

Growing Our Mission by serving new populations and providing new services to existing members and providers.

Community Value through promoting our mission and the value CenCal Health adds to the community.

Innovation in reduction of costs, improvement in the quality of care, and strengthened member experience.

Culture of Excellence by developing people, processes, and technology for our future growth.

Financial Strength in being good stewards of public funds.

Section B: Provider Resources

B1: CenCal Health Contact Information

Contact Information	Phone Numbers
Member Services	(877) 814-1861
Provider Services	(805) 562-1676 (800) 421-2560 ext. 1676 Email: providerservices@cencalhealth.org
Claims Operations	(805) 562-1083 (800) 421-2560 ext. 1083 Email: cencalclaims@cencalhealth.org
Medical Management	(805) 562-1082 (800) 421-2560 ext. 1082 (877) 931-2227 Care to Care (Radiology Benefit Manager) Utilization Management (805) 562-1082 Option 1 Case Management (805) 562-1082 Option 2 Adult Disease Management (805) 562-1082 Option 4 Pediatric Case Management & CCS (805) 364-4950 Behavioral Health (805) 562-1600
Population Health	(805) 617-1997 Email: populationhelth@cencalhealth.org
Pharmacy Services	(805) 562-1080 (800) 421-2560 ext. 1080
Video & Telephonic Interpreter Services	Phone Interpreter Service (800) 225-5254 Operator Customer Code: 48CEN

	Video Remote Interpreter Service Web Address: cencalhp.cli-video.com VRI Access Code: 48cencalhp Email: certifiedlanguages.com (877) 814-1861 - Sign Language
Finance-Recoveries Unit	(805) 562-1081 (800) 421-2560 ext. 1081
Fraud, Waste & Abuse Reporting	Compliance Hotline: 1 (866) 775-3944 Mail: CenCal Health Attn: Compliance Investigator 4050 Calle Real Santa Barbara, CA 93110 Email: compliance@cencalhealth.org

URLs for above hyperlinks:

Medi-Cal Provider Manuals are available on the Department of Health Care Services' website.

http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

CenCal Health Contact Us

www.cencalhealth.org/contact-us/

The Compliance Alert Line

<https://cencalhealth.alertline.com/gcs/overview>

The CenCal Health Provider Compliance website

<https://www.cencalhealth.org/providers/suspect-fraud/>

B2: Provider Resources on CenCal Health's Website

The CenCal Health website provides information, including resources and other helpful tools, to providers and members. Resources include, but are not limited to, the following:

- Contracted providers may use CenCal Health Provider Portal Restricted website to verify eligibility, check the status of CenCal Health claims, and submit authorizations. Providers must register with [CenCal Health](#) to utilize this restricted site.

- Provider Manual — provides general information relative to the provision of healthcare goods and services to CenCal Health members.
- Provider Directory — Search by CenCal Health program, health network, name, specialty, or location.
- Health and Wellness — Materials are available in PDF format and downloadable in all of CenCal Health's threshold languages.
- Provider Communications — This includes the monthly provider newsletter, as well as Provider Updates based on recent Operating Instruction Letters received by the Department of Health Care Services.
- CenCal Health Policies and Procedures— A complete library of CenCal Health policies by program located in the 'Forms, Manuals and Policies' section of the website.

URLs for above hyperlinks:

CenCal Health Provider Portal

www.cencalhealth.org/providers/provider-portal/

CenCal Health Provider Manual

www.cencalhealth.org/providers/forms-manuals-policies/provider-manual/

Search CenCal Health Provider Network Directory

www.cencalhealth.org/providers/search-provider-network/

CenCal Health & Wellness

www.cencalhealth.org/health-and-wellness/

CenCal Health Policies & Procedures

www.cencalhealth.org/providers/forms-manuals-policies/policies-procedures/

B3: Provider Education and Training Resources

CenCal Health provides education and training on a variety of topics to CenCal Health's provider network to facilitate the relationships between CenCal Health and the providers, and also between the providers and the members to improve the quality of care and services our members receive.

Our training events are primarily developed and presented by the Provider Services Department with input from other departments and may feature a guest speaker. The training events are continually updated to reflect the most current information available.

The Provider Services Department hosts the training events; issues invitations; and arranges the time, location, and refreshments or meal if the training event is in person. Webinar/online trainings are also hosted and recorded so they are made available on our website under [Provider Training & Resources](#). The trainings conducted may consist of one or more speakers, visual and/or audio aids, and handouts. The length of the program varies depending on the content and concludes with a question and answer period.

New Provider Orientation (NPO) - When a new provider contracts with CenCal Health, the Provider Services Representative (PSR) conducts a training which the provider is given instruction and materials to help them become acquainted with CenCal Health's programs, the billing processes, provider/member grievance policy, member eligibility, Cultural Competency, SPD, Linguistic & Interpreter Services, authorizations, incentive programs (PCP's only), provider portal website demonstration, etc.

This training is offered within 10 working days and completed 30 calendar days after the provider is placed on active status. A CenCal Health onboarding packet, and New Provider Training Operations Guide is made available to the provider during onboarding, and inclusive of a full review of CenCal Health's website. The onboarding packet contains much of the information the provider will need to begin to provide care and services to the members of CenCal Health's programs, and a New Provider Training Attestation Form is signed stating that they received such material. The Provider Services Representative is available by phone and e-mail for questions, and will make return visits as needed.

Provider In-Service Office Visits & Training Visits - Provider Service Representatives (PSR) routinely visit provider offices on an informal basis to help maintain a mutually beneficial relationship between the provider and CenCal Health. These visits create opportunities for the provider to ask questions and for the Representative to deliver current information or materials. Meetings may be scheduled at the provider's request and convenience to discuss specific issues. CenCal Health's PSR, Member Services Representative, Claims Representative, Quality Representative, and Health Service's Population Health staff may be included in these meetings.

CenCal Health Provider Orientation - This training is offered quarterly via online training webinars for the convenience of providers throughout Santa Barbara and San Luis Obispo counties. It covers a multitude of topics including CenCal Health's programs, provider/member grievance policy, member eligibility, Linguistic & Interpreter Services, Behavioral Health Services, Transportation Benefit, Health Education resources, Cultural Competency, SPD, and provider resources. This training course is a refresher course for provider offices and new office staff.

Claims Billing - This training is coordinated by a Claims Service Representative within the Claims Department for office staff that are unfamiliar with medical billing for CenCal Health, and individualized assistance with claims submissions. It is provided as needed and is tailored to the provider's needs. This individualized training is usually the result of a provider's request for in-depth instruction or due to problems noted by the Claims Department that results in excessive numbers of the provider's claims being pended or denied.

Facility/Medical Record Audit - CenCal Health's Quality Management Coordinator (QMC) assists PCP sites in preparing for Facility and Medical Record Audits as required by the Department of Health Care Services (DHCS). Audit tools, relevant P&Ps, and other related materials are provided to the PCP site when an audit is scheduled, and the QMC contacts the PCP site to discuss critical elements and answer questions prior to the audit date.

Quality Health Initiative Training - These trainings are held to focus on various tools to assist providers in their role as case manager, and to assist in providing additional education for program improvement projects. Quality programs include education on a variety of topics such as Asthma Management, Adolescent Well Care, and SMART Programs.

CenCal Health Member Eligibility Overview Training - This training is offered quarterly via online training webinars. Provider staff learn how to manage a CenCal Health Member's eligibility, education on Share of Cost (SOC), CCS members, and how to check along with checking and learn the many different resources you can utilize with checking eligibility status via the Provider Portal. This training includes a live demonstration of the provider portal and how to use its features, i.e.. This training may also be scheduled at the provider's request via an In-Service training with a Provider Services Representative.

Authorization Overview Training – This training is offered quarterly via online training webinars. Provider staff learn about Referral Authorization Forms (RAF), Treatment Authorization Requests (TAR) and other types of authorizations that may be required for medical review and necessity. During this training staff receive a demonstration of the provider portal and how to use the provider portal tools to submit online, and check authorization status. This training may also be scheduled at the provider's request via an In-Service training with a the Provider Services Representative.

Targeted Programs (New Initiatives) - There are a variety of programs offered to specific audiences, or specific topics that may be conducted annually or on an as-needed basis. They are usually developed to serve an identified need or to inform certain provider types of provider-specific issues. These may include training events specific to information on changes to CenCal Health's programs.

Cultural Competency, Health Literacy and Communicating with Seniors and Persons with Disabilities Training - Cultural Competency and Health Literacy Tools provide appropriate health care and services for our members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups. In addition, The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities. Both public and private hospitals and health care facilities must provide services to people with disabilities in a nondiscriminatory manner. CenCal Health provides yearly Cultural Competency, Health Literacy and SPD education to improve provider-patient communication.

This process shall include an educational program for providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to posting information on websites as well as other methods of educational outreach to providers during an In-Service Provider Services Representative New Provider Orientation (NPO) Training.

Resources: There are a variety of educational materials and resources distributed to the providers by CenCal Health during each provider training

and provided to all registered Provider staff.

Attendee Tracking: Attendees are required to register for online webinars, and then tracked for participation. If hosted via Face to Face seminar, attendees are given name badges, and asked to sign an Attendance Sheet. This allows the Provider Services Department to maintain records of attendance and provide a roster from which certificates of attendance or completion may be issued. Attendance is documented through the Case Tracking process.

Confidentiality and Privacy: No individual identifiable health information or protected health information is used or released during these training events. Blinded information may be used, or “dummy data” is created, for demonstration purposes.

Monitoring: Attendees are requested to fill out an evaluation form after the training is completed. This allows the Provider Services Department to assess the appropriateness of the program's subject matter, content, and method of presentation. Suggestions for new topics may be obtained from providers, staff, internal committees such as the Provider Advisory Board, or may be the result of revised regulatory or procedural issues.

URLs for above hyperlinks:

CenCal Health Provider Training & Resources
www.cencalhealth.org/providers/provider-training-resources/

Welcome to the Network
www.cencalhealth.org/providers/welcome-to-the-network/

B4: Advanced Health Care Directive

CenCal Health members should fill out an Advanced Health Care Directive. It is a simple form that tells doctors and loved ones exactly what type of care a patient wants at the end of their life, or if they cannot speak for themselves. CenCal Health has a free, simple, and member-friendly form that is available on our website. Members can print it out, complete the form, and sign it. Then they should give copies to their doctor(s), family, and/or friends. This will make sure that the member's values and choices are met. To download the easy-to-use Advanced Healthcare Directive form in [English](#) or [Spanish](#), please visit the CenCal Health website at www.cencalhealth.org.

If members cannot print the online form, we can send them a free copy. Please contact CenCal Health's Health Education Request Line at **(800) 421-2560 ext. 3126**.

URLs for above hyperlinks:

CenCal Health Advanced Health Care Directive site and forms:
<https://www.cencalhealth.org/health-and-wellness/advanced-healthcare-directive/>

B5: Community Resources

Please note that CenCal Health is providing information as a resource only. It is not our intention to imply that organizations offer services that are covered benefits for our members.

CenCal Health partnered with findhelp.org, a company that created and maintains a social care network that makes it easy to find local, state, and federal resources available in our communities. Many of these resources are free or determined by income levels.

Please visit the [Community Resources](#) page on CenCal Health's website to view local community resources in your area. This information can also be found at <https://www.cencalhealth.org/community/community-resources/>

B6: Telemedicine Policy

CenCal Health will reimburse for care delivered via telemedicine per DHCS guidelines. Please see DHCS telemedicine billing FAQ

- Capitated providers: Telemedicine services will be included in capitation payment.
- FFS providers: Telemedicine services will be paid at the contracted rate.
- BH providers: Telemedicine services for mental health is allowable. If you are a FQHC and offer mental health services, please submit your claims with the Medi-Cal allowable codes. Visit DHCS' website and search "COVID-19 Medi-Cal Services and Telemedicine Notice." Click here for more information.

Virtual Communication (audio and video)

Providers should continue to attempt to provide telemedicine services via HIPAA-compliant telecommunications methods. However, according to the Department of Health and Human Services (HHS) issued on March 23, 2020, "...covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telemedicine without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telemedicine during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications."

We ask that you notify our Provider Services department by email psrgroup@cencalhealth.org if you intend to provide services over an electronic platform.

Telephonic Communication (audio alone)

This includes a brief communication with another practitioner or with a patient, who in the case of COVID-19, cannot or should not be physically present (face-to-face). Medi-Cal providers may be reimbursed using the below Healthcare Common Procedure Coding System (HCPCS) codes G2010 and G2012 for brief virtual communications.

HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and management (E/M) service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

Additionally, CenCal Health will waive the authorization requirement for ages 21 and over for CPT codes 98966-98968 to support providers in delivering care by telephone without video through June 30, 2020.

Section C: Contracting and Credentialing

C1: Join the CenCal Health Network: Provider Contracting

Join us in our effort to provide quality healthcare to those in need. Please contact our Provider Services Department at (805) 562-1676, and our team will guide you through the process.

To be reimbursed for non-emergent services for an eligible member of a health program administered by CenCal Health, providers must have an Executed Agreement with CenCal Health. To provide emergent care to any Medi-Cal member, providers need only be enrolled in the State Medi-Cal program.

As of January 1, 2018, CenCal Health is required by federal law to ensure all contracted providers are enrolled in the Department of Health Care Services (DHCS) Medi-Cal Program. Providers who enroll through DHCS are eligible to provide services to Medi-Cal Fee for Service (FFS) beneficiaries as well as CenCal Health Medi-Cal beneficiaries. The State's Provider Application and Validation for Enrollment PAVE portal is a web-based application designed to simplify and accelerate the State Medi-Cal enrollment process. Providers can utilize the portal to complete and submit applications, report changes to existing enrollments, and respond to requests for continued enrollment or re-validation.

The State's [PAVE portal is a web-based application](#) designed to simplify and accelerate the State Medi-Cal enrollment process. Providers must utilize the portal to complete and submit applications, report changes to existing enrollments, and respond to requests for continued enrollment or re-validation. Please be sure to maintain current and accurate information about yourself and/or your group, as data submitted through PAVE comprises the database DHCS uses to understand the network of Medi-Cal providers in California. This is important even if you only see CenCal Health members and never submit claims for Fee-For-Service members.

If you are not enrolled and have questions, please contact the Provider Services Department and our team will assist you with the enrollment process.

As your relationship and experience with us grows, your PSR as well as staff from other CenCal Health departments, will be on hand to answer questions, complaints and concerns, assist with member issues, process claims and authorizations for referrals and/or treatment, and for on-going training.

URLs for above hyperlinks:

DHCS PAVE Provider Enrollment
www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

C2: Provider Directory and Attestation of Practice Information

The Department of Managed Health Care (DMHC) released Senate Bill (SB) 137 in December 2016, indicating uniform standards and timely updates for all Managed Care Plan Provider Directories. Provider Directory standards will allow members to receive and search accurate, up-to-date information regarding physicians, hospitals, clinics, and other providers contracted with the Health Plan's network.

Among other requirements, SB 137 requires health plans to comply with the following:

- Publish and maintain accurate provider directory or directories with information on contracting providers.
- Verify provider directory information with contracted providers on a periodic basis.
- Update the provider online directory weekly and printed directory quarterly.
- Ensure contracted providers notify the Health Plan when they are accepting new patients or no longer accepting new patients.

In an effort to provide Members and Providers with the most current information, CenCal Health's Provider Directory is updated on a routine basis. Providers need to verify and attest to the accuracy of their information via the CenCal Health Provider Roster at least every six months. Providers can request a pre-populated roster from CenCal Health that contains all data currently on file. Providers can submit changes, additions and deletions from this pre-populated roster. Additionally, Providers can download a blank roster template from the CenCal Health website and submit updates. The blank roster template can be found on CenCal health's website at: <https://www.cencalhealth.org/providers/provider-profile-and-practice-changes/>

For any questions regarding attesting to your data, you can contact the Provider Services Department at (805) 562-1676 or send an e-mail to providerservices@cencalhealth.org. If you would like to obtain a printable copy of the provider directory, please visit our website: <https://www.cencalhealth.org/providers/search-provider-network/> or contact the Provider Services Department for assistance.

C3: Credentialing and Recredentialing

CenCal Health always strives to provide the best care possible to our members. Like most managed care organizations, we have programs in place to improve the quality of care delivered to our members. As part of this quality improvement program, we have a process to gather and verify the credentials of providers in our network.

CenCal Health developed and implemented a credentialing and recredentialing process to evaluate the practitioners who practice within its delivery system initially and on an ongoing basis. We have chosen to implement a rigorous credentialing process because we assume responsibility for managing the healthcare of our members, and ensuring our providers meet quality standards is part of this responsibility. Well-defined policies and procedures identify the practitioners that are subject to this process, define the credentials assessed and methodology used to make credentialing decisions, and identify the parties responsible for the credentialing process. Information assessed includes (but is not limited to) licensure, relevant training or experience, and any issues that may affect the care delivered within the managed care setting. Verification of this information from approved primary sources is essential to ensure that decisions are based on the most accurate, current, and complete information available. At recredentialing, CenCal Health also considers data derived from practice experience within the organization as part of its evaluation, as well as complaints and other member satisfaction measures.

To ensure that CenCal Health has obtained correct information and makes fair credentialing decisions, practitioners are afforded certain rights during the credentialing and recredentialing process, including the right to review information obtained to support their credentialing application.

CenCal Health's credentialing process is based on National Committee of Quality Assurance standards. In some instances, the credentialing and recredentialing process may be delegated, wholly or in part, to another entity with oversight by CenCal Health to ensure the same standards are being met.

C4: Primary Source Verification

	MD/DO	Chiropractor	DPM	Physician Executive	PA / PA-C	NP	CRNA	Nurse midwife	Allieds	Orgs
NPI (PSV) /SSN / DOB / Full name	√	√	√	√	√	√	√	√	√	NPI / Tax ID / W9
Medical/professional school	√	√	√	√	√	√	√	√	√	N/A
Internship/Residency/ (Fellowship optional)	√	One year	√	√	N/A	N/A	N/A	N/A	N/A	N/A
Board Certification (not required unless otherwise stated) (PSV w/in last 6 mos.)	ABMS	N/A	ABFAS ABPM	ABMS	NCCPA <small>(required at grad., renewal optional)</small>	AANP ANCC NCC PNCB	NBCRNA <small>(required)</small>	AMCB <small>(required for CNM)</small>	N/A	N/A
Specialty / Degree (based on residency, fellowship or board cert.)	√	√	√	Specialty Physician executive	Specialty based on activity	Specialty based on activity	√	√	√	Accreditation
License (State) (PSV w/in last 6 mos.)	√	√	√	√	√	√	√	√	√	Business License
License (National)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	√	RD's	N/A
License (other states)	√	√	√	√	√	√	√	√	N/A	N/A
DEA Certificate (CA address, all schedules) (current at time of approval)	√	N/A	√	Not required	√	√	N/A	√	Optometrists (optional) —not all sched.	N/A
Hospital Admitting Privileges	√	N/A	√	Not required	N/A	N/A	N/A	√	N/A	N/A

(PSV – current at time of approval) (or admitting alternative plan)											
Medi-Cal enrollment/date (PSV)	√	√	√	N/A	√	√	√	√	√	√	√
Supervising MD / DOSA	N/A	N/A	N/A	N/A	√	√	N/A	√	N/A	N/A	N/A
Working locations / cred contact	√	√	√	√	√	√	√	√	√	√	√
OIG search (PSV w/in last 6 mos.)	√	√	√	√	√	√	√	√	√	√	√
NPDB search (PSV w/in last 6 mos.) CIN-BAD (DC's only)	√	CIN-BAD	√	√	√	√	√	√	√	N/A	N/A
Malpractice insurance (current at time of approval)	√	√	√	√	√	√	√	√	√	√	Liability
AMA/AOIA profile (initial MD/DO's)	√	N/A	√	√	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Work history over last 5 years (explanation of gaps > 6 mos.)	√	√	√	√	√	√	√	√	√	N/A	N/A
Attestation / Release (w/in 1 year)	√	√	√	√	√	√	√	√	√	√	N/A
Quality Summary (FSR for all PCP's) (Member grievances and peer review data for Recreds only)	√	√	√	N/A	√	√	√	√	√	N/A	N/A

* Medical School/Residency information is verified once, at the time of initial credentialing.

Credentialing and Recredentialing verification processes comply with NCQA credentialing standards as they pertain to primary source verification.

It is necessary to have the provider's application, resume and/or curriculum vitae with a signed liability release dated within the past twelve (12) months to initiate a credentialing or recredentialing process.

C5: Facility Site, Medical Record and Physical Accessibility Reviews

CenCal Health conducts facility site (FSR), medical record (MRR), and physical accessibility (PARs) reviews for all Primary Care Providers as a requirement for participation in CenCal Health programs.

Reviews of sites for primary care providers (PCPs) that serve Santa Barbara Health Initiative (SBHI) and San Luis Obispo (SLOHI) members are conducted utilizing the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Full Scope Site Review Survey and Medical Record Survey Tool. PCP sites must achieve a passing FSR score prior to members being assigned. The FSR includes an on-site inspection and interview with the office personnel.

The MRR is based upon a survey of 10 randomly selected medical records per physician and is comprised of pediatric and/or adult records, depending on the type of practice. The MRR review includes, but is not limited to, a review of format, legal documentation practices, documentary evidence of the provision of preventive care, and coordination of primary care services.

FSR and MRR audit tools are scored as per DHCS requirements, and corrective action plans (CAPs) are provided when needed. Critical element deficiencies always require a CAP. CAPs must be completed and verified within the timeframes dictated by DHCS. CenCal Health nurse reviewers who are certified by DHCS perform all FSR/MRR reviews and are available to provide assistance in completing CAPs.

After the initial full scope survey, the maximum time period before the next required full scope FSR/MRR is three years. CenCal Health may review sites more frequently, or when determined necessary based on prior findings.

Physical Accessibility Review Survey (PARS) assessments enable CenCal Health to collect and publish information about the physical accessibility of a provider site for seniors and persons with disabilities (SPDs), and they are performed on all PCP sites during the initial FSR. PARS are also performed on other provider sites such as specialists, ancillary, and community-based adult services providers that serve a high volume of SPDs. PARS assessments examine access to parking, the exterior building, elevators, interior building, exam rooms, and restrooms. The survey will also identify if an exam room has a height adjustable exam table and accessible weight scale for those with disabilities.

To download materials to prepare for a [Facility Site/Medical Record Review](#) please visit the CenCal Health website at www.cencalhealth.org or email Provider Services for assistance at psrgroup@cencalhealth.org.

If you relocate your office, or employ or contract with a new primary care physician, please notify CenCal Health's Provider Services Department at (805) 562-1676 or psrgroup@cencalhealth.org.

C6: Access to Care Standards

According to the Department of Health Care Services and the Medicaid Managed Care Final Rule: Network Adequacy Standards, CenCal Health is required to adopt access to care standards for its provider network. Please see the table below for a summary of the regulations. At least annually, we contact our providers to conduct appointment availability and after-hours access surveys. The survey format or methodology, as well as the provider types contacted, may change periodically based on DHCS direction. We appreciate the ongoing collaboration with our providers as we all strive toward the common goal of providing excellent care to the members we serve. Contact the Provider Services Department at (805) 562-1676 or email ProviderServices@cencalhealth.org for questions.

Appointment Time	Standard Time Frame
Non-urgent Primary Care Appointment	Within 10 business days to appointment from request
Non-urgent Specialty Appointment	Within 15 business days to appointment from request
Non-urgent OB/GYN Specialty Care Appointment	Within 15 business days to appointment from request
Non-urgent OB/GYN Primary Care Appointment	Within 10 business days to appointment from request
Non-urgent Mental Health (non-psychiatry) Outpatient Services Appointment	Within 10 business days to appointment from request
Non-urgent Ancillary Services Appointment (for diagnosis or treatment)	Within 15 business days to appointment from request
Urgent Care Appointment	Within 48 hours for services that do not require prior approval Within 96 hours for services that do require prior approval
Emergency Care	Immediately
+Primary Care Triage and Screening	Within 30 minutes
Mental Health Care Triage and Screening	Within 30 minutes
Wait Time in Office	Within 30 minutes
After Hours Care	24 hours a day
Telephone Access	24 hours a day

+ reflects “Triage” or “screening”, and means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

C7: Terminating a Provider

In the event that a provider is terminated from the CenCal Health network, we must make every effort to ensure our obligations to the State and to our Members' care are met, including ensuring Members are notified and reassigned to another CenCal Health participating provider when appropriate.

As a Provider, it is important to ensure you notify CenCal Health in writing at least 60 days of any changes to your practice, including if you are moving, retiring, or resigning that may result in terminating your Agreement with CenCal Health. CenCal Health is required to notify DHCS of Provider Termination as applicable to our contract.

Providers must also ensure that access to Members' records and other information necessary to ensure any needed coordination or transfer of care to another provider may occur, as required by your Agreement, and by State and other laws. Providers are obligated to cooperate and assist with ensuring our Members' needs are met during this time.

CenCal Health will acknowledge your written Notice of termination with a returned acknowledgement notice via email, and also ask you to complete a Provider Exit Survey to gain valuable feedback and to identify opportunities for improvements to programs and services.

Section D: Provider Responsibilities

D1: Role of the Primary Care Provider (PCP)

The primary care provider (PCP) plays the central role in structuring care for CenCal Health members. The PCP is the main provider of healthcare services for CenCal Health members and is responsible for the delivery of healthcare to his or her assigned members. CenCal Health's model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services furnished by other physicians or providers to meet the needs of the member.

D2: Responsibilities of the Primary Care Provider (PCP)

PCP responsibilities include, but are not limited to:

- Provide care for the majority of healthcare issues presented by the member, including preventive, acute, and chronic healthcare.
- Supply risk assessment, treatment planning, coordination of medically necessary services, referrals, follow up and monitoring of appropriate services, and resources required to meet the needs of the member.
- Case manage assigned members to ensure continuity of care, facilitate access to appropriate health services, reduce unnecessary referrals to specialists, minimize inappropriate use of the emergency department,

- maintain appropriate use of pharmacy benefits, and identify appropriate health education materials and interventions.
- Assure access to care 24 hours a day, seven days a week, including accommodations for urgent care, performance of procedures, and inpatient rounds.
 - Coordinate and direct appropriate care for members, including:
 - Initial Health Assessments
 - Preventive services in accordance with established standards and periodicity schedules as required by age and according to the American Academy of Pediatrics (AAP) and the United States Preventive Services Task Force (USPSTF)
 - Second opinions
 - Consultation with referral specialists
 - Follow-up care to assess results of primary care treatment regimen and specialist recommendations
 - Special treatment within the framework of integrated, continuous care
 - Screen members for mental health and substance use difficulties, provide treatment within scope of practice, and assist the member with referrals to appropriate treatment providers.
 - Coordinate the authorization of specialist and non-emergency hospital services for members.
 - Contact and follow up with the member when the member misses or cancels an appointment.
 - Record and document information in the member's medical record, including:
 - Member office visits, emergency visits and hospital admissions.
 - Problem lists, including allergies, medications, immunizations, surgeries, procedures, and visits.
 - Efforts to contact the member.
 - Treatment, referral, and consultation reports.
 - Lab and radiology results ordered by the PCP.
 - Authorization to Release Information to and from the member's mental health and substance use provider.
 - Make reasonable attempts to communicate with the member in the member's preferred language, using available interpretation or translation services.
 - If the member is currently receiving mental health or substance abuse treatment services, coordinate the member's care with the existing mental health or substance use provider.

D3: Service Obligations of Hospital for CenCal Health's Medi-Cal Members

Licensing

The Hospital shall be:

- Licensed as a general acute care hospital in accordance with the requirements of the California Health Facilities Licensure Act (Health and Safety Code, Sections 1250 and following) and the regulations thereunder
- Certified as a hospital provider by Medicare and Medi-Cal

- Accredited by JCAHO to provide Covered Services
- Equipped, staffed, and prepared to provide benefits to CenCal Health Members

If the Hospital provides distinct part skilled nursing beds, the Hospital shall be licensed as a general acute care hospital with distinct part skilled nursing beds in accordance with Section 1250.8 of the Health and Safety Code and the licensing regulations contained in Titles 22 and 17 of CCR. If the Hospital ceases to provide this service for any reason it must notify CenCal Health 90 days prior to the cessation of the availability of these services.

Services Provided by Hospital

The Hospital shall provide benefits to Members, subject to the availability of appropriate facilities and services. Members are entitled to receive inpatient services when ordered by a Member's responsible physician or other qualified health practitioner, and said services should be provided in accordance with regulations as set forth in 22 CCR Section 51301. Services to be rendered are subject to exclusions, limitations, exceptions, and conditions as agreed to by the Hospital and CenCal Health.

Services Not Covered and Not Compensated

The Hospital shall not be obligated to provide Members services that are not covered under CenCal Health's contract with the State, and CenCal Health shall not be obligated to compensate the Hospital for the said services.

Services Rendered on Basis of Availability of Facility

The Hospital shall not discriminate against CenCal Health's Members in connection with its admission policies or practices. Admission of Members to the Hospital for care and treatment must be based upon the severity of medical need and the availability of Hospital facilities and Hospital services. The decision as to whether or not a Member requires specific medical care or hospital services is a professional medical decision to be made by the Member's attending physician in accordance with applicable medical staff rules and regulations.

Additionally, the Hospital is expected to use its best efforts to maintain its current facilities, equipment, and patient service personnel (as well as allied health personnel) to meet its obligation to provide covered benefits to CenCal Health's Members. However, the Hospital is not obligated to provide said Members with inpatient, outpatient, or emergency services that are not maintained by the Hospital due to religious or other reasons.

Standard of Care

Members shall be entitled to receive hospital care in accordance with recognized hospital, professional, and applicable State licensing laws and regulations.

Emergency Services

Emergency Services, as defined in the Agreement, means those services required for alleviation of a medical or behavioral health condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the patient's health (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious risk of harm to self or others due to a mental health or substance use disorder.

Emergency Services, both in the emergency department and for inpatients who require immediate treatment for unexpected conditions, requires the professional care of a physician who is immediately available on or near Hospital premises. The Hospital must arrange for such services to be available to all patients, including CenCal Health's Members, requiring such services by a contract with physicians who have agreed to provide required emergency services on an independent contract basis. CenCal Health is responsible for payment for treatment and services rendered by these physicians.

Care of CenCal Health members who present to the emergency department with a mental health emergency must be coordinated with County Behavioral Health Services who covers Psychiatric in-patient services. CenCal Health members, who after stabilization of a mental health or substance use emergency do not require in-patient admission, must be provided with a referral to appropriate mental health and substance treatment services.

CenCal Health's Members are permitted to obtain emergency services immediately at the nearest provider when the need arises. The Hospital shall provide Emergency Services to each Member who presents at the emergency department and who, within the judgment of the attending physician, requires such Emergency Services. CenCal Health is responsible for payment for treatment and emergency room facility services rendered by the Hospital.

Prescribed Drugs Under Emergency Circumstances

When the course of treatment provided to a Member under emergency circumstances requires the use of drugs, a sufficient quantity of drugs (including for the treatment of a mental health or substance use condition) shall be provided to the Member to last until he/she can reasonably be expected to have a prescription filled.

Discharge Summaries and Emergency Room/Urgent Care Center, or Treatment/Examining Room Reports

The Hospital shall prepare a written discharge summary within thirty (30) days of the CenCal Health Member's discharge and shall use best efforts to send a copy of said

summary to the Member's Primary Care Physician (PCP) or case manager. The Hospital shall also prepare a written treatment summary of services, including mental health and substance use services rendered in the Hospital's emergency department, urgent care center, or treatment/examining room within thirty (30) days of treatment of a Member and shall use best efforts to send a copy of said summary as indicated above and consistent with all applicable federal and state confidentiality and patient consent requirements. Said discharge summaries and treatment summaries shall contain information ordinarily prepared by the Hospital and provided to third-party payers at the time a bill for service is submitted, and are important for the Member's PCP to receive for continuity of care issues and optimum case management. Failure by the Hospital to send such summaries to the PCP or case manager may result in CenCal Health's denial of payment for services rendered. *Notwithstanding the above, Hospital may discontinue sending the PCP or Case Manager a copy of the discharge summary if another means of communication to inform said physicians of the services rendered to CenCal Health's Members is agreed to by the parties.*

Miscellaneous Requirements

The Hospital agrees to:

- Verify a CenCal Health Member is eligible for benefits under the Program indicated on their identification card.
- Comply with the CenCal Health's Utilization Management Protocols.
- Use its best efforts to ensure that discharge planning is performed for all CenCal Health Members who are admitted to the Hospital in as expeditious and timely a manner as is possible, and to attempt to place these Members, who otherwise qualify for placement in skilled nursing facilities, in alternative non-institutional settings whenever possible.
- Permit the Member to be visited by his/her domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.
- Assure that domestic partners are treated on an equal basis with spouses, including coverage of dependents of domestic partners as with spouses.
- Work with CenCal Health to assure that Cultural and Linguistic needs of CenCal Health's members are met. Further information on Providing Culturally Competent Care, go to **D7: Providing Culturally Competent Care** in Member Services of this Provider Manual.

D4: PCP Requests for Member Reassignment

On occasion, a Primary Care Physician (PCP) may encounter a situation that warrants a request to have a patient reassigned to a new PCP. CenCal health has established a mechanism to address these issues. Outlined below is the procedure that should be followed when submitting a request.

- **Make Sure You Have an Appropriate Reason to Request Reassignment**

APPROPRIATE Reasons to Request Reassignment of a Patient:

- **Contractual:** Pediatric PCPs may request reassignment of a member who is beyond their scope of services, e.g., members who are beyond their contracted age limit or who become pregnant.

Note: if maximum age limit is 16, the member cannot be removed from case management until the 17th birthday is reached. Typically, reassignments based on age happen automatically.

- **Non-Contractual:** These reasons (listed below) often involve lack of cooperation on the part of the member, although in some instances the goal is to create the most beneficial relationship between member and provider. It is important that you supply sufficient information in the "Provider Remarks" section to enable us to determine if the request meets the criteria. Requests based on single or minor infractions will be denied. We also ask that you describe how you have attempted to correct the problem. **Requesting member reassignment should be the last resort!**
 - *Inappropriate Assignment by CenCal Health* - e.g., the member has re-linked to a provider who previously requested his reassignment to different providers.
 - *Member Drug Seeking* - specify how the behavior is manipulative in attempting to obtain substantially more medication than is warranted.
 - *Member Circumventing Case Management/Demanding Referrals/Self Directing Care* - give examples that demonstrate a pattern.
 - *Member Abusing ER Services* – this will only be approved for extraordinary cases of deliberate circumvention of case management and will require extensive documentation.
 - *Language/Cultural Barriers*- this alerts CenCal Health that assignment to another provider (e.g., Spanish-speaking) may be more beneficial for the member. The member will be offered the choice of choosing a provider more familiar with his language/cultural needs.
 - *Member "No Shows"* - list dates member no-showed for appointments without calling to cancel despite reminder calls/appointment verification (at least **3** separate dates in the **past year** to establish a pattern).
 - *Member Non-Compliant with Treatment* - there must be potentially serious consequences due to non-compliance and a disregard for medical advice on the member's part.
 - *Member Abusive/Threatening/Disruptive* - the member may just be disruptive, i.e. calling 20 times in one day for a non-urgent matter, or it may be more serious. Be specific with incidents/quotations. If the member poses an immediate threat to self or others, call the appropriate authorities!
 - *Unable to Establish Interpersonal Relationship* - describe how a personality conflict or difference in belief systems significantly affects care.
 - *Member Lying/Theft* - if the theft is of a serious nature (e.g., blank prescriptions) or there is an attempt of fraud, the appropriate authorities should be notified.

- **INAPPROPRIATE reasons to request reassignment of a patient:**
 - PCPs cannot request reassignment of patients simply because they are very sick and have a diagnosed condition that would be difficult to manage. It is vital that these patients have a "medical home" with a PCP to coordinate their care. To allow such shifting of patients is neither good medicine nor is it in the best interests of any participating physician.
 - When a member moves to another area of the county and needs a PCP in closer proximity to his new home, the member must initiate a re-selection through a member services representative. If you know a member has moved, please contact CenCal Health Member Services and be prepared to provide the member's new address or phone number.
 - A change to special class is needed:
 - for those members that move to a skilled nursing facility by the first day of the month and are expected to remain there for more than 30 days, for members that have moved out of county, and for members with certain other circumstances, inform the Member Services department at (877) 814-1861.

If you would like assistance to determine if a particular situation meets the criteria for reassignment requests, or if you have questions about the process, please call provider services at (805) 562-1629.

- **Submitting a Reassignment Request via the CenCal Health Website**

The PCP who wishes to request reassignment of a member under their case management should do so via the CenCal Health Provider Portal restricted site. You must have a valid username and password to access this feature; please follow the instructions for contacting the webmaster to obtain these if you have not done so already.

 - Select "PCP Reassignment Requests" from the list of forms. Enter your provider ID# (your NPI) and the member's Client ID# (CIN). If the member is not currently eligible or is not assigned to you, you will receive an error message informing you of this.
 - If the member is eligible and assigned to you, you will be taken to a different screen where you will choose the reason for your request from a drop-down list. All contractual and non-contractual reasons for requesting reassignment that meet CenCal Health criteria are on this list.
 - You must enter supporting information in the "Provider Remarks" section, e.g., dates of member no shows, examples of how the member is non-compliant or abusive, etc. If left blank, the program will prompt you to enter your remarks.
 - When complete, click the "Submit" button on the form. Use the "Back" button to return to the previous screen to enter another request.
 - Requests will be approved if the documentation supports the request. If the documentation submitted was unclear or insufficient, the Provider Services Quality Liaison will pend the request and an email will

be generated to you requesting additional information. Requests submitted on the 10th of one month through the 9th of the next month are processed by the cut-off date (9th day of each month at 4pm). An email will be generated to the PCP after the request has been processed to verify approval and the effective date. PCPs may also check the status of the request by using the "Query" button on the PCP Reassignment Request form.

- The member's new assignment becomes effective the first day of the following month after the 9th. The PCP who requested the reassignment continues to be responsible for the member's care until the new assignment is in effect.
- If you do not have internet access, please call Provider Services at (805) 562-1629 for further instructions.

D5: Medical Records

Each primary care office is responsible for maintaining adequate medical records of patient care. Records must be maintained in accordance with applicable federal and state privacy laws. All medical records must be maintained in a manner consistent with professional practices and prevailing community standards. Providers are required to maintain records for ten years after termination of agreement with CenCal Health, including the period required by the Knox-Keene Act and Regulations, and Medicare and Medi-Cal programs.

If an unauthorized disclosure of member information occurs, providers are to notify CenCal Health immediately upon discovery by calling CenCal Health's Toll-Free 24 Hour Compliance Hotline at (866) 775-3944.

Records Copying Surcharges

All Providers are expected to furnish any medical or other records requested by CenCal Health during the usual course of business at the Provider's expense, including but not limited to those for utilization review, case management, quality programs, claims adjudication, grievances and appeals, member records following termination, or other activities CenCal Health must conduct to administer its programs and benefits, or at the request of any governmental agency.

D6: Resources for Seniors and Persons with Disabilities

Members of CenCal Health have the right to have full access to health plan benefits, regardless of disabilities. We want to assist providers in meeting this obligation and ensure that members can receive the healthcare services they need. Below is information about our services and community resources that provide services to the disabled.

CenCal Health Services

- Non-Emergency and Non-Medical Transportation - CenCal Health contracts with Ventura Transit System Inc.: (855) 659-4600

See “Non-Emergency Medical Transportation” in **E9: Non-Emergency Medical Transportation Services and Non-Medical Transportation** for more information on this service.

- *Non-Medical Transportation* – Non-medical transportation services are provided as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service.
- *Interpreter Services* – telephonic, video when criteria is met and American Sign Language interpreter services.
- *Language Line Telephonic Services* - We also give providers 24/7 free access to Certified Languages International - for our members, which provides an interpreter by phone for over 140 languages. Instructions are in the Provider Manual and on our website in the Language Assistance Program resources Section N.
 - *Hearing Impaired* – can contact Member Services by using the California Relay Service at 711 or TTY (833) 556-2560.
- *Member Handbook* – available in large print and other formats upon request.
- *Information on wheelchair accessibility* and assistance with access issues.

Providers can reach a CenCal Health Member Services Representative by calling (877) 814-1861 option 3.

Education: Visit the Cultural Competency & Health Literacy page at CenCal Health's website for additional resources and learning opportunities to integrate into your practice.

URLs for above hyperlinks:

Cultural Competency & Health Literacy

www.cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-and-health-literacy/

D7: Providing Culturally Competent Care

CenCal Health does not discriminate against individuals based on race, ethnicity, national origin, religion, age, mental or physical disability or medical condition, genetic information, sexual orientation, or gender, including gender identity and gender expression.

What is Cultural Competence?

Cultural competence is the ability of healthcare providers and organizations to understand and respond effectively to the cultural and language needs of patients. Cultural competence requires organizations and their personnel to:

- Value diversity
- Assess themselves
- Manage the dynamics of difference
- Acquire and institutionalize cultural knowledge
- Adapt to diversity and the cultural contexts of individuals and communities served

Adapted from Cross et al., 1998 and US Department of Health and Human Services, Office of Minority Health, 2000.

Why is Cultural Competence Important?

The racial, ethnic, and socio-cultural diversity of patients may create challenges as you strive to deliver high quality services. Personal factors can consciously or unconsciously influence how we interact with patients. Becoming self-aware of one's own attitudes, beliefs, biases, and behaviors - and recognizing that they can impact patient care - can help providers improve their patients' quality of care, access to care, and health outcomes.

U.S. Department of Health and Human Services' Office of Minority Health, 2013

Cultural Competence in Practice

Interpreter Services: CenCal Health members may request the use of telephonic or video Interpreter Services. For details about accessing Interpreter Services for patients, see Section N of this Manual.

Gender/Sexuality Non-Discrimination: Providers should strive to normalize inclusion of all gender identities and sexual orientations within the practice setting, to create inclusive service delivery systems, and to use gender neutral language and labels.

CenCal Health is required to treat members consistent with their gender identity. CenCal Health also provides transgender members with the same level of healthcare benefits that are available to non-transgender members, including all medically necessary services and/or reconstructive surgery.

Health Literacy: Understanding health information can be difficult for everyone, and particularly for those with poor reading skills, those who speak limited English, older adults, and those on "information overload." Patients may not understand medication instructions, when to schedule follow-up, etc. For Health Literacy resources to assist in effective patient communication, see [Section P, P1](#) of this Manual.

Education: Visit the Cultural & Linguistic Resources and Cultural Competency & Health Literacy page at CenCal Health's website for additional resources and learning opportunities to integrate into your practice.

URLs for above hyperlinks:

Cultural & Linguistic Resources
www.cencalhealth.org/providers/cultural-linguistic-resources/

Cultural Competency & Health Literacy
www.cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-and-health-literacy/

Section E: Covered Benefits and Services

E1: Covered Services Overview

"Covered Services" refers to those medically necessary items and services available to a member through CenCal Health's Medi-Cal program. These services include

Medi-Cal covered services and optional Medi-Cal services administered by CenCal Health, as well as Medi-Cal covered services not administered by CenCal Health.

Eligibility

The Providers are responsible for verifying the recipient is eligible with CenCal Health for the date of service. Eligibility can be verified via the [Provider Portal](#) at www.cencalhealth.org.

MEDI-CAL COVERED SERVICES ADMINISTERED BY CenCal Health Medi-Cal Covered Services administered by CenCal Health include, but are not limited to, the following:

- Physician services
- Hospital inpatient and outpatient services
- Whole Child Model (WCM) and California Children's Services (CCS)
- Emergency care services
- Health education programs
- Home healthcare
- Maternity care services
- Family planning
- Lab tests and X-rays
- Prenatal care
- Immunizations
- Durable medical equipment
- Medical supplies
- Prosthetics and orthotics
- Pediatric preventive services (CenCal Health CHDP Program)
- Immunizations
- Prescription drugs
- Transportation — emergency
- Transportation — non-emergency medical transportation services
- Hospice
- Long-term care and skilled nursing care services
- Physical therapy/occupational therapy
- Vision services
- Mental health services
- Behavioral Health Treatment (BHT)

MEDI-CAL COVERED SERVICES NOT ADMINISTERED BY CenCal Health

CenCal Health does not administer certain Medi-Cal covered services. The following identifies these covered services, as well as where to obtain more information in this provider manual about referrals for these services:

- Non CenCal Health members with California Children's Services (CCS) eligibility
- Dental services (see **F1: Dental Services for Medi-Cal Members**)
- Substance Use Services (see **F3: County Substance Use Services**)
- Local education agency services. For more information about Medi-Cal covered services, please visit the [Medi-Cal website](#).
- Specialty mental health services (see **F2: Specialty Mental Health Services**)

URLs for above hyperlinks:

DHCS Medi-Cal Providers
<https://www.medi-cal.ca.gov/>

E2.1: Acupuncture Services

CenCal Health members may access Acupuncture services to prevent (two per month total), modify or alleviate the perception of severe, persistent, or chronic pain resulting from a generally recognized medical condition.

Types of Services Provided

SBHI & SLOHI Members – The following Acupuncture Services are Covered Benefits for Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) members:

- Services rendered by a physician, podiatrist or certified acupuncturist who is enrolled in the Medi-Cal program, eligible to provide Medi-Cal services and contracted with CenCal Health as a provider.
- Limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
- Acupuncture used with or without electric stimulation of the needles.
- Used to treat a condition also covered by other modalities.
- Subject to two services per month (total).

Authorizations

Acupuncture services are subject to the two-services per month Medi-Reservation limitation. Referrals and prior authorizations are not required for a member to access Acupuncture services. A Medi-Reservation must be made by the Acupuncturist for each visit provided. Services may be reserved by completing and submitting the Medi-Reservation Form found on CenCal Health's website, <https://www.cencalhealth.org/>. A confirmation number will be given once the Service is reserved. For more information please refer **H5: Medi-Reservations** of the Provider Manual.

A provider shall be reimbursed by CenCal health for Covered Services rendered to members as indicated in Exhibit A of the provider's Allied Amendment Agreement.

E2.2: Audiology Services

CenCal Health Members may access Audiological Services - to determine hearing loss and evaluate the need for a Hearing Aid. Access to Hearing Aids includes both the instrument, and the fitting of the Hearing Aid, education, adjustments and repairs as indicated below.

"Audiologist" shall mean a person who performs procedures of measurement, appraisal, identification and counseling related to hearing and disorders of hearing; provides rehabilitation services for the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and recommends and evaluates Hearing Aids. An audiologist shall be licensed by the Speech Pathology and Audiology Examining Committee of the State Board of

Medical Quality Assurance or similarly licensed by a comparable agency in the State in which he/she practices.

“Audiological Services” shall mean services for the measurement, appraisal, identification and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior, and the recommendation and evaluation of Hearing Aids.

“Hearing Aid” shall mean any aid prescribed for the purpose of aiding or compensating for impaired human hearing loss.

Type of Services

Audiological Services provided, by acting within the scope of their practice as authorized by California law, are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI).

Audiological Services	<ul style="list-style-type: none"> • Audiological evaluation to measure the extent of hearing loss and hearing aid evaluation to determine the most appropriate make and model of hearing aid.
Hearing Aid Services	<ul style="list-style-type: none"> • Hearing Aids, monaural or binaural, including ear mold(s), hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, and repairs. • Surgically implanted FDA-approved hearing devices, including implantable cochlear devices for bilateral, profoundly hearing impaired individuals who are not benefited from conventional amplification (hearing aids).
Non Covered Charges	<ul style="list-style-type: none"> • Batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase. Charges for a hearing aid, which exceeds specifications, prescribed for correction of a hearing loss. • Replacement parts for hearing aids, repair of hearing aid after the covered 1-year warranty period and replacement of a hearing aid more than once in any period of 36 months

Covered Audiology and Hearing Aids Benefits for SBHI & SLOHI Members

Audiological Services for SBHI & SLOHI Members are considered Limited Services. One initial or first visit may be allowed for each Member in a six-month period for each Provider, and it is included in the two services per month limitation that applies to all Limited Service Providers. This initial visit, which does not require prior authorization from the Primary Care Physician (PCP) or Attending Physician, should be billed with HCPCS Code X4502.

Authorizations

Referrals and prior authorizations are not required for a member to access Audiology services. A Medi-Reservation must be made by the Audiologist for each visit provided. Authorization will not be granted to extend Audiology services beyond the services reserved through a Medi-Reservation. Services may be reserved by

completing and submitting the Medi-Reservation Form found on CenCal Health's website, <https://www.cencalhealth.org/>. A confirmation number will be given once the Service is reserved. For more information please refer to **H5: Medi-Reservations** of the Provider Manual.

Documentation of Services

The Audiologist shall document services by completing a claim form and submitting the form to CenCal Health. The Audiologist shall also provide documentation to the member's PCP.

E2.3: Chiropractic Services

Type of Services Provided

Services provided by Chiropractor providers are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI). A member may access Chiropractic services for treatment of the spine and neck by means of manipulation.

Covered Chiropractor Services for SBHI and SLOHI

SBHI & SLOHI Member Benefit Restriction

Chiropractic services are a restricted benefit for SBHI and SLOHI Members. The following chiropractic services are covered benefits for Members and services meeting the criteria listed below for SBHI & SLOHI Members. Two visits per month total.

- Services rendered by a Chiropractor who is enrolled in the Medi-Cal program, eligible to provide Medi-Cal services, and contracted with CenCal Health as a provider.

SBHI and SLOHI – The following chiropractic services are covered benefits for SBHI & SLOHI.

- Services limited to the treatment of the spine rendered by a licensed Chiropractor.
 1. Members 20 years old and under
 2. Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the nursing facility to be covered. Members can be identified by an Aid Code of 13, 23, 53 or 63 when checking eligibility
 3. Rendered by a Federally Qualified Health Center (FQHC)

Authorizations

Referrals and prior authorizations are not required for a member to access Chiropractic services. A Medi-Reservation must be made by the Chiropractor each visit provided. Services may be reserved by completing and submitting the Medi-Reservation Form found on CenCal Health's website, www.cencalhealth.org. A confirmation number will be given once the Service is reserved. For more information please refer to **H5: Medi-Reservations** of the Provider Manual.

Should a Chiropractor feel that x-rays are necessary, he/she should contact the Member's PCP or attending physician and discuss the need for these diagnostic

services. The PCP or attending physician may authorize said services to a contracted radiology or X-Ray provider.

E2.4: Hearing Aids Services

Services provided by Hearing Aid providers are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI).

A member may access Hearing Aid services for hearing aids, replacements and repairs of hearing aid appliances.

Covered Hearing Aid Services for SBHI, SLOHI

CenCal Health covers hearing aids when supplied by a hearing aid dispenser on the prescription of an otolaryngologist, or the attending physician. An audiological evaluation, including a hearing aid evaluation performed by, or under the supervision of, the above prescribing physician, or by a licensed audiologist, is required.

The following procedures are Covered Benefits as indicated below:

- A hearing test to measure the extent of hearing loss.
- A hearing aid evaluation to determine the most appropriate make and model of hearing aid.
- Hearing aids, monaural or binaural, including ear mold(s), hearing aid instruments, the initial battery, cords and other ancillary equipment.

Non Covered Charges for SBHI, SLOHI

- Batteries or other ancillary equipment, except those covered under the terms of the initial Hearing Aid purchase. Charges for a Hearing Aid which exceeds specifications prescribed for correction of a hearing loss.
- Replacement parts for Hearing Aids or repair of Hearing Aid after the covered 1 year warranty period.
- Replacement of a Hearing Aid more than once in any period of 36 months.

Authorizations

Referrals and prior authorizations are not required for a member to access Hearing Aid services. A Medi-Reservation must be made by the Hearing Aid Supplier for each visit provided. Authorization will not be granted to extend Hearing Aid services beyond the services reserved through a Medi-Reservation. Services may be reserved by completing and submitting the Medi-Reservation Form found on CenCal Health's website, www.cencalhealth.org. A confirmation number will be given once the Service is reserved. For more information please refer to **H5: Medi-Reservations** of the Provider Manual. (Please reference **E13: Whole Child Model (WCM) and California Children's Services (CCS)** for CCS Guidelines as this is different for CCS members)

E2.5: Home Health Services

CenCal Health members may access health services provided at their home, including skilled medical services, if they are homebound.

Note: Hearing Aid authorization guidelines are different for CCS members. Please refer to **E13: Whole Child Model (WCM) and California Children's Services (CCS)** for CCS Guidelines.

Covered Services

SBHI, SLOHI, Members – The following Home Health services are Covered Benefits for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI), members:

- Diagnostic and treatment services that can reasonably be provided within the home.
- Nursing care provided by a registered or licensed vocational nurse, or a licensed home health aide who is working in conjunction with a registered or licensed vocational nurse.
- Rehabilitation and/or, physical, occupational, or speech therapy, as determined by the physician to be medically necessary.
- Medical supplies if they are given by approved Providers and are in accordance with the Member's written treatment plan.
- The use of medical appliances if it is in accordance with the Member's written treatment plan.

Authorizations

Prior authorization is required for services beyond case evaluation. Certain services performed in conjunction with the initial case evaluation are exempt from this requirement. Please refer to the Medi-Cal manual for exemptions at [Medi-Cal: Provider Manuals](#). Authorization request must include a written treatment plan attached to a Treatment Authorization Request form (TAR). TAR's must include the CPT code. PP2 Members-A Home Health provider must request a referral in the form of a Referral Authorization Form (RAF) from the member's Primary care Provider and obtain prior authorization through a Medical Authorization form (AR) which can be found at cencalhealth.org. A written treatment plan must be attached to the AR. Please refer to the Authorization **H4: RAF Exceptions** for further instructions.

E2.6: Hospice Services

CenCal Health members may access hospice services so that they may receive palliative care and assistance with the physical, emotional, social, and spiritual discomfort associated with the last phases of life due to the existence of a terminal disease.

Covered Services

SBHI and SLOHI – The following Hospice services are Covered Benefits for Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative:

- Services connected to the medical management of the pain and symptoms associated with a terminal illness and its related conditions.
- Skilled nursing services, certified health aide services, and homemaker services under the supervision of a qualified registered nurse.
- Physician services.
- Physical, occupational, and speech therapy services, for the purpose of symptom control, or to enable members to maintain activities of daily living and basic functional skills.
- Short-term inpatient care arrangements related to the terminal illness.

- Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the management of the terminal illness and related conditions.

A separate payment will not be made for the following Hospice services:

- Hospital, Nursing Facility (Level A & B), and Home Health Agency care.
- Medical equipment and supplies, and pharmaceuticals.
- Medical transportation.

Authorization – Providers must obtain a pre-authorization for all levels of hospice care via an approved Treatment Authorization request (TAR) for CenCal Health members. Please refer to **H3: Request for Authorization** for more information.

Note: Hospice and Palliative care are available to CCS members. Please refer to **E13: Whole Child Model (WCM) and California Children’s Services (CCS)** of the Provider Manual.

E2.7: Incontinence Supplies

CenCal Health follows the State of California Medi-Cal guidelines for incontinence supplies in most cases. Please review those guidelines in the Incontinence Medical Supplies: An Overview in the Durable Medical Equipment and Medical Supplies (DME) section of the Medi-Cal Provider Manual as published by the California Department of Healthcare Services (DHCS), www.medi-cal.ca.gov. Unless otherwise noted below, providers of incontinence supplies are subject to Medi-Cal guidelines.

The below guidelines provide CenCal Health's criteria for providing incontinence supplies and submitting claim submissions. They are meant to assist you in ensuring a timely outcome for payment of incontinence supplies. If you have any questions regarding the information described in these Protocols, please refer to the Contact section at the end of this document.

Prescription

A prescription is required for any provision of incontinence supplies for CenCal Health Members. Providers of incontinence supplies are required to use, and must obtain, the Incontinence Supplies Prescription Form as published by the California Department of Healthcare Services (DHCS) and provided in the Medi-Cal Provider Manual (www.medi-cal.ca.gov).

- The prescription is only valid for a six (6) month period, and it must be renewed every six (6) months for updated medical justification.
- The member's physician (Primary Care Physician or attending physician) must write individual prescriptions prior to the delivery of service, ordering only those supplies necessary for the care of that member.
- The physician's medical record must show each prescription with the anticipated rate of use for that specific item as well as the specific causal diagnosis and the type of incontinence for which the incontinence supplies were prescribed.
- A copy of the current prescription must be retained in the member's medical chart.

Limitations

Incontinence Supplies have both a quantity per period threshold as well as a monthly dollar limit threshold under Medi-Cal guidelines. CenCal Health waives the quantity limitations for some incontinence supplies and instead institutes a maximum monthly dollar threshold. Incontinence Supplies are limited to \$165, including sales tax and markup, per member, per calendar month, but if supplies over the \$165 limit are medically necessary, a Treatment Authorization Request (TAR) is required and can be submitted to override the limit.

Affected supplies under the cost limitation include disposable briefs (diapers), protective underwear (pull on products), underpads, belted undergarments, shields, liners, pads and reusable underwear. The procedure codes listed in the Medi-Cal Manual at [Medi-Cal: Part 2 – Durable Medical Equipment and Medical Supplies \(DME\)](#) are under the monthly dollar threshold of \$200 and have their quantity limitation waived up to the \$200 threshold.

Incontinence Creams & Washes

Continued Services:

- Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy. Please include modifier TH on your claim form. This modifier can be used for up to sixty (60) days after delivery.
- Crossover claims for Members also covered by Medicare. If the service is unable to be billed to Medicare, i.e., Medicare non-covered items, then the service will not be covered by CenCal Health.

In addition, the following members are covered By CenCal Health.

- Members 20 years old and under.
- Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the nursing facility to be covered. Members are identified by an Aid Code of 13, 23, 53 or 63 in the Eligibility Screen.

Authorizations

Prior authorization is required for services, reference **Section H: Referrals and Authorizations** of the Manual.

E2.8: Laboratory Services

Covered Services

Services provided by Laboratory providers, acting within the scope of their practice as authorized by California law, are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI) - include the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other types of examination of materials derived from the human body, for purposes of diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

Covered Laboratory Benefits

- Maternity Care: laboratory testing, includes genetic and alpha-fetoprotein testing.

- Outpatient hospital and other outpatient facilities: Diagnostic services includes laboratory services.
- Inpatient hospital services: include laboratory services.
- Diabetes management and treatment: includes outpatient services and laboratory testing.
- For SBHI including at a minimum: Cholesterol, triglycerides, microalbuminuria, HD/LDL, and Hemoglobin A-1C (Glycohemoglobin).
- Testing to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications

Access

Member may access laboratory services in the following settings: hospital/inpatient in both acute and rehabilitation hospitals; outpatient hospital and other outpatient facilities, for pregnancy and maternity care, when receiving services under the diabetes management and treatment benefit, and as directed by physicians and other health professionals.

Authorizations

Prior authorization is required for services. To verify authorization requirements please refer to **Section H: Referrals and Authorizations** of the Manual.

Specific Authorization of Laboratory Services

Laboratory services which are provided in a setting in which required authorization would be obtained by the facility, i.e. an inpatient hospital setting, would not require additional authorization.

E2.9: Lactation Services

Covered Services:

One of the benefits offered to eligible women under the SBHI and SLOHI programs is the services of an International Board Certified Lactation Consultant (IBCLC).

Lactation services are available for mothers needing information on breastfeeding. The focus of these lactation consultations is to assess the woman's ability to breastfeed and resolve issues they may have surrounding breastfeeding. CenCal Health has authorized IBCLCs to provide up to a two-hour consultation in the office, home or hospital without prior authorization.

Authorizations

Prior authorization is required for services. To verify authorization requirements please refer to **Section H: Referrals and Authorizations** of the Manual.

E2.10: Nursing Facility

Covered Services:

Provider is a Nursing Facility, also known as a Skilled Nursing Facility or Long Term Care facility. Provider shall adhere to the rules and regulations pursuant to the California Health Facilities Licensure Act, and to the rules and regulations of the Medi-Cal and Medicare programs. Nursing Facility represents and warrants that it is currently and for the duration of this Agreement shall remain certified under Title 18 of the Federal Social Security Act. Nursing facilities that serve members for a primary

psychiatric disorder are not covered by CenCal Health, but by the local County Mental Health Plan.

DEFINITIONS

“Day” or “Days” means calendar days, unless otherwise noted.

“Facility Services” includes, but is not limited to, the following services when ordered by a Member’s responsible physician or other qualified health practitioner and rendered to Members in accordance with the W&I Codes, applicable sections of 22 CCR for Skilled Nursing Facilities and intermediate care facilities, subject to any exclusions, limitation, exceptions, and conditions as may be set forth in the Agreement.

- Room and board.
- Nursing and related care services. Skilled Level of Care therapy needs per MD direction.
- Commonly used items of equipment, supplies and services used for the medical and nursing benefit of Members in applicable provisions of the State Medi-Cal program referenced in 22 CCR.
- Administrative services required in providing Inpatient Services.

“Nursing Facility” means a facility that is licensed as either a Skilled Nursing Facility or an Intermediate Care Facility.

“Skilled Nursing Facility” means any institution, place, building, or agency which is licensed as a Skilled Nursing Facility by DHCS or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR § 51215 (except that the distinct part of a hospital does not need to be licensed as a Skilled Nursing Facility) and has been certified by DHCS for participation as a Skilled Nursing Facility in the Medi-Cal program. The term “Skilled Nursing Facility” shall include the terms “skilled nursing home”, “convalescent hospital”, “nursing home”, or “Nursing Facility”.

“Skilled Nursing Facility Level of Care” means that level of care provided by a Skilled Nursing Facility meeting the standards for participation as a provider under the Medi-Cal program as set forth in 22 CCR § 51215.

SERVICES

Coverage shall be provided in accordance with the standards set forth in 22 CCR § 51335 and any or all Attachments to Exhibit A and in the Member’s EOC.

ACCESS

Nursing Facility shall provide Medi-Cal Facility Services to Members, subject to the availability of appropriate skilled nursing care services and/or intermediate care services. Nursing Facility shall additionally adhere to the provisions of the State Long Term Care Manual.

Authorizations

Prior authorization is required for services. To verify authorization requirements please refer to **Section H: Referrals and Authorizations** of the Manual.

E2.11: Nutrition Educators

Covered Services:

Nutrition Educators providing medical nutrition therapy (MNT) services are reimbursable by CenCal Health when conducted by a Registered Dietitian (RD) working as or with a contracted provider. The following services are covered under the CenCal Health Nutrition benefit:

- Outpatient medical nutrition therapy necessary to enable Members requiring diabetes management to understand diabetes diet and nutrition, blood sugar monitoring, and medication therapy as prescribed by a Provider.
- Outpatient medical nutritional therapy and counseling to members diagnosed with an eating disorder (i.e. anorexia, bulimia) to assist in normalization of eating patterns and nutritional status and assist with medical monitoring in collaboration with the rest of the treatment team.
- Nutritional counseling as a health education benefit for multiple medical conditions, including but not limited to morbid obesity, uncontrolled hypertension, hyperlipidemia, and renal or cardiovascular disease, when conducted by contracted Nutrition Educators.
 - Nutritional services for members with an eating disorder, irrespective if the member is receiving outpatient mental health services through CenCal Health or county mental health.

Under the benefit, members are entitled to an initial assessment not to exceed 4 hours per year; a re-assessment and intervention not to exceed 4 hours per 1 month; and group sessions not to exceed 8 hours per a 9 month period. Re-assessments and additional services beyond these benefit limitations require prior authorization (these limits do not apply to children under 21 due to EPSDT regulations). Members under the age of 21 do not have treatment limits apart from medical necessity criteria.

Authorizations - Please refer to the [Referral Authorization Process](#) section on the CenCal Health website and reference the [RAF Exceptions List](#) for information on services that do not require a RAF, and [Section H, H20](#) of the Provider Manual for Attachment A for general authorization requirements.

If a hospital provides nutrition education to Members on an inpatient basis at the hospital, such educational efforts should be noted in the member's chart; however, no additional payment for these services outside of the agreed upon hospital rates will be paid to the hospital.

Reference:

RAF Exceptions List <https://www.cencalhealth.org/~media/files/pdfs/providers/providers/provider-materials/2019rafexceptionslist.pdf?la=en>

E2.12: Optician Services

Covered Services:

A Member may access Optician Services when the Member requires a prescription to be filled for prescription lenses and related products as well as the fitting and adjusting of such lenses and spectacle frames and when the service is a Covered Service under CenCal Health.

Type of Services Provided Services provided by dispensing opticians, acting within the scope of their practice as authorized by California law, are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI) and Prenatal Plus 2 (PP2) members include filling prescriptions of physicians for prescription lenses and related products, fitting and adjusting such lenses and spectacle frames. A dispensing optician is also authorized to act on the advice, direction and responsibility of a physician or optometrist in connection with the fitting of a contact lens or contact lenses. A dispensing optician may also be referred to as Optician.

Covered Services:

- Members 20 years old and under.
- Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the nursing facility to be covered. Members are identified by an Aid Code of 13, 23, 53 or 63 when checking eligibility.
- Eye glasses, when necessary and prescribed.
- Contact lenses, when medically necessary and prescribed.
- Visits for fitting glasses and contact lenses.

E2.13: Optometry Services

Covered Services:

Optometry and Optician Service for SBHI and SLOHI Members include an eye examination every two (2) years. Eyeglasses are a covered benefit every two (2) years for Members who are exempt from the optional benefit elimination. A referral from the Member's PCP is not necessary.

Members in the following category are eligible for eyeglasses, eye appliances and related services in addition to optometry services.

- Members 20 years old and under.
- Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the nursing facility to be covered. Members are identified by an Aid Code of 13, 23, 53 or 63 when checking eligibility.

Authorizations

Prior authorization is required for services. To verify authorization requirements please refer to **Section H: Referrals and Authorizations** of the Manual.

E2.14: Vision Services

Covered Services:

One routine eye exam with refraction every 24 months, with a second eye exam with refraction when medically necessary.

Eye appliances when prescribed by a physician or optometrist, including prescription eyeglasses, eyeglass frames, contact lenses (when medically necessary), low vision aids (excluding electronic devices) and prosthetic eyes.

CenCal Health covers optometry services for the following types of Medi-Cal members:

- Members who have full-scope Medi-Cal benefits and who are under age 21.
- Members who are residents of a Nursing Facility.
- Members whose course of treatment began prior to July 1, 2009, and continues after July 1, 2009.
- Members receiving services due to a condition that might complicate a pregnancy.
- Members receiving optometry services in a hospital outpatient department.

Authorization

Please refer to **Section H: Referrals and Authorizations** - Provider shall follow the guidelines set forth in the EDS Medi-Cal Provider Manual at [Medi-Cal: Part 2 – Vision Care](#).

E2.15: Physical Therapy Services

Covered Services:

A Member may access Physical Therapy services (PT) when treatment is prescribed by a physician to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psycho-social disabilities, physical illness or advanced age.

Type of Services Provided

Services provided by Physical Therapy providers are covered for Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) members. Services include treatment prescribed by a physician or podiatrist of any bodily condition by the use of physical, chemical and other properties of heat, light, water, electricity or sound, and by massage and active, resistive, or passive exercise. Services also include Physical Therapy evaluation, treatment planning, treatment, instruction, consultations and application of topical medication.

Covered PT Benefits for SBHI, SLOHI

The following procedures are Covered Benefits:

- PT services are a covered benefit only when services are provided pursuant to a written prescription of a CenCal Health physician or podiatrist, which is within the scope of their medical practice.
- PT services are only covered when care is rendered in the Provider's office or in an outpatient department of a hospital facility.
- PT services must be performed by licensed and registered therapists.
- PT services are also covered when the Member is an inpatient at an acute care hospital, in a skilled nursing facility, or at home.

Note: Pediatric members may be eligible for physical therapy services through the CCS Medical Therapy Program (MTP). Please refer to <https://www.dhcs.ca.gov/services/ccs> for more information.

Authorizations

- Prior authorization is required for services, to verify authorization process please refer to **Section H: Referrals and Authorizations** of the Provider Manual, Attachment A. For outpatient physical therapy, prior authorization is required beyond the first 18 visits.

E2.16: Emergency Medical Transportation Services

Covered Services:

CenCal Health members may access Emergency Medical Transportation services when the member's medical or physical condition or mental health condition requires immediate medical care and precludes the usage of public transportation or driving.

Types of Services Provided

SBHI and SLOHI Members (correction) – The following Emergency Medical Transportation Services are Covered Benefits for Santa Barbara Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) members:

- Medical Transportation to the nearest hospital capable of meeting a member's medical needs independent of the hospital's contract status.
- Transportation to a second facility, when the nearest facility served as the closest source of care, but the member requires a facility with a higher level of care.
- Transportation of a member on an involuntary psychiatric status according to Welfare and Institutions Code 5150 & 5585 to the nearest hospital for medical clearance and/or to a designated facility as determined by the County Mental Health Department for further evaluation and treatment.
- Ground Medical Transportation services must be rendered by a provider whose ground transport vehicles are licensed, operated, and equipped in accordance with applicable state and local statutes, ordinances, and regulations.
- Air Medical Transportation services must be rendered by a provider whose air transport vehicles are certified by the Department of Health Care Services (DHCS) and Federal Aviation Agency (FAA), have an air medical transportation provider number, and the transport meets one of the following conditions:
 - The medical condition of the member precludes the use of other forms of medical transportation.
 - The member's location or the nearest hospital capable of meeting the member's medical needs is inaccessible by ground medical transportation.
 - Other considerations make ground medical transportation not feasible.

Non-Covered Services

SBHI and SLOHI (correction) Members – The following Emergency Medical Transportation Services are Non-Covered Benefits for SBHI and SLOHI members:

- Transportation services other than those specifically provided for in the provider's agreement and in the member's Evidence of Coverage, including

but not limited to passenger car, taxi, or other form of public or private conveyance.

- Services rendered by a provider who is not eligible with Medi-Cal, except in cases of out-of-state emergencies
- Services outside the scope of an Emergency Medical Transportation Provider as set forth in the EDS Medi-Cal Provider Manual.

SLOHI (correction) Members under the age of 21 and Hospital to Hospital transports -

Provider must submit an attachment to the claim that supports that an emergency existed. The statement must include the following:

- The name of the person or agency that requested the service.
- The nature of the emergency.
- The name of the hospital the member was transported to.
- Clinical information on the member's condition.
- The reason emergency transportation was considered medically necessary.
- The name of the physician that accepted responsibility for the member.

Authorizations

Prior authorization is required for services. To verify authorization requirements please refer to **Section H: Referrals and Authorizations** of the Manual.

E2.17: Durable Medical Equipment

DME providers will be responsible for first determining the eligibility of members to receive services, for meeting the elements of and documenting services as indicated below, and in order to receive payment, for submitting claim forms to CenCal Health.

Type of Durable Medical Equipment (DME) Services Provided

Services provided by DME providers, acting within the scope of their practice as authorized by California law, are covered for Santa Barbara Health Initiative (SBHI), and San Luis Obispo Health Initiative (SLOHI) members.

“Durable Medical Equipment” is equipment prescribed by a licensed physician to meet medical equipment needs of the member that:

- Can withstand repeated use.
- Is used to serve a medical purpose.
- Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly.
- Is appropriate for use in or out of the member's home.

DME Benefit

DME as prescribed includes, but is not limited to, the purchase or rental of equipment such as ambulatory items, wheelchairs, oxygen and related respiratory equipment, hospital beds and accessories, bathroom safety equipment, and home monitoring equipment for diabetes, asthma and high blood pressure management. In addition, Medically Necessary repairs and replacement of DME as authorized unless necessitated by misuse or loss.

Limitations of DME

For custom made manual wheelchairs and power operated wheelchairs/scooters, a "wheelchair and living environment evaluation" must be performed by a person with one or more of the following certifications:

- Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified Assistive Technology Suppliers (ATS), Assistive Technology Professional (ATP), or Rehabilitation Engineering Technologists (RET)
- Registered with National Registry of Rehabilitation Technology Suppliers (NRRTS) or Rehabilitation Technology Suppliers (RTS)
- Licensed Occupational or Physical Therapist with continuing education in Rehabilitation Technology
- Documented rehabilitation equipment training through a recognized wheelchair manufacturing company

A certified technician may be employed by the DME provider; however, CenCal Health has contracted with specific certified evaluators to perform these evaluations in the provider's area.

Non-Covered Charges of DME

- Home monitoring equipment except for those provided under the diabetes management program, or to treat asthma and/or high blood pressure.
- DME provided by a non-participating Provider; customization of living environment or motor vehicles; experimental equipment; items that duplicate the function of other equipment; and other convenience items not generally used primarily for medical care. Examples include, but are not limited to, exercise equipment, air conditioners or heaters, lighting devices, orthopedic mattresses, recliners, seat lift chairs, elevators, waterbeds, household and furniture items.

Maximum Rental

Except for life support equipment, such as ventilators, when previously paid rental charges equal the purchase price of the rented item, the item is considered to have been purchased and no further reimbursement to the Provider shall be made unless repair or maintenance of the item is separately authorized.

Authorizations

DME providers are required to obtain a referral for certain services prior to providing services in the form of a prescription (Rx) from the member's PCP. Prescription (Rx) forms are available through CenCal Health or the Medi-Cal website, www.medi-cal.ca.gov.

Additional authorization for DME products

- Prior Authorization, in the form of a **Treatment Authorization Request (TAR)** for SBHI and SLOHI is required for the purchase, repair or maintenance, or cumulative rental of DME subject to the conditions, restrictions and exceptions as specified below:
 - **Purchases** exceeding \$100.00 (cumulative within a calendar month)
 - **Rentals** exceeding \$50.00 (cumulative with a 15-month period)
 - **Repairs or maintenance** exceeding \$250.00 (cumulative within a calendar month)

- Purchase, rental or repair of **any miscellaneous item** over \$50.00
- Prior Authorization is also required for the provision of oxygen when more than 500 cubic feet is provided during one calendar month.
- Purchase, rental, repair or maintenance of unlisted devices or equipment may require Authorization as set forth in CenCal Health regulations.
- Authorization shall not be granted for DME when a household item will adequately serve the member's medical needs.
- Authorization for DME shall be limited to the lowest cost item that meets the member's medical needs.
- Authorization for customized DME for transitional inpatient care members, skilled nursing facility or intermediate care facility inpatients may be approved if it meets applicable regulatory provisions.

E2.18: Medical Supplies

CenCal Health follows the State of California Medi-Cal guidelines for medical supplies. Please review those guidelines in the Durable Medical Equipment and Medical Supplies (DME) section of the Medi-Cal Provider Manual as published by the California Department of Healthcare Services (DHCS), www.medi-cal.ca.gov. CenCal Health recommends that you contact contracted in network DME providers first, and if contracted provider unable to provide the service, CenCal Health would allow outside services from non-contracted providers.

If providing incontinence supplies, please refer to the Protocols for Incontinence Supplies in **E2.7: Incontinence Supplies** of the Manual.

Prescription

A prescription is required for any provision of medical supplies for CenCal Health Members. The prescription should be kept on file in the member's medical chart and is subject to audit by the plan.

- The prescription is only valid for a six (6) month period, and it must be renewed every six (6) months for updated medical justification.
- The member's physician (Primary Care Physician or attending physician) must write individual prescriptions prior to the delivery of service, ordering only those supplies necessary for the care of that member.
- The physician's medical record must show each prescription with the anticipated rate of use for that specific item.
- A copy of the current prescription must accompany all authorization requests.

Limitations

Medical Supplies have a quantity per period threshold. Please refer to the Medi-Cal Manual, located at <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mcsup.pdf> to determine the quantity allowed per timeframe.

Exceeding the quantity threshold as set forth in the Medi-Cal Manual requires approval through a Treatment Authorization Request (TAR) for members of the Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI).

Authorization (TAR/AR) Submission

If exceeding the monthly quantity allowance, please complete an authorization. TARs/ARs may be completed by submitting electronically through the Provider Portal using the eRAF or eTAR feature located on the CenCal Health website, www.cencalhealth.org. To request a Username and Password to submit web authorizations, please contact the Webmaster at webmaster@cencalhealth.org.

The maximum timeframe for a medical supply authorization is six (6) months. All TARs/ARs require documentation of medical necessity as defined below:

- Request only those items that will exceed the quantity threshold.
- From and through dates not to exceed a six (6) month timeframe.
- The primary ICD-10-CM code should be entered in the diagnosis field.
- For requests over the quantity limitations, please provide, in addition to the prescription, written medical justification explaining why the member needs supplies in excess of the thresholds set by Medi-Cal. This description should be in a narrative format. The provider should inform the ordering physician of quantity limitations so that medical justification can properly address the specific condition of the member.
- Enter Units of Service and Quantity fields as indicated below.

Units vs. Quantity

The Units of Service field on a TAR/AR represents the number of months for which the item is being requested to not exceed six (6) months. The Quantity field on a TAR/AR represents the number of items being provided each month. Please do not calculate the total items being requested on the TAR/AR for the entire timeframe; that calculation will be handled internally upon the plan processing the authorization.

- If submitting authorization through CenCal Health's website, please ensure that the documentation required for the authorization is faxed to the plan on the same day as the submittal of the web TAR/AR. Please add the TAR/AR number to each page of the documentation to ensure the information being faxed is attached to the correct authorization. Paper authorization forms should be mailed or faxed with all supporting documentation included.
- If there is a delay in providing the required documentation, please notify the Health Services Department at (805) 562-1082 or directly to the plan staff member requesting the additional documentation needed to process the authorization.
- Email is the most effective means of communication for authorizations; if you are not already receiving email notifications for authorization submission or if you need to update your email address, please contact the Provider Services Department at (805) 562-1676.

E2.19: Occupational Therapy

Type of Services Provided

Services provided by Occupational Therapy (OT) providers are covered for Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) members. These services include treatment prescribed by a physician to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psycho-social disabilities, physical illness or advanced

age. Members may access Occupational Therapy services including: occupational therapy evaluation, treatment planning, treatment, instruction, and consultations.

Covered OT Benefits for SBHI, SLOHI

The following procedures are Covered Benefits:

- OT services are a covered benefit only when services are provided pursuant to a written treatment plan or written prescription of a CenCal Health physician or podiatrist, which is within the scope of their medical practice. See the Provider Manual for additional information on what is required in the prescription or written treatment plan
- OT services are only covered when care is rendered in the Provider's office, in an outpatient department of a hospital facility, or as authorized to be provided in the Member's home
- OT services must be performed by licensed and registered therapists
- OT services are also covered when the Member is an inpatient at an acute care hospital, in a skilled nursing facility, or at a rehabilitation hospital

Non-Covered Charges

- Non-authorized services are not covered

Occupational Therapy providers will be responsible for:

- First determining the eligibility of members to receive services
- For meeting the elements of Occupational Therapy services and for documenting services as indicated below
- For submitting claim forms to CenCal Health.

Eligibility

Occupational Therapy providers must confirm that the member presenting in his/her office is eligible for services under CenCal Health and is assigned to the referring PCP for the month in which he/she is to render services. This can be accomplished by verifying eligibility through one of CenCal Health's systems. Information regarding eligibility is in the Member Services Section of this Provider Manual.

In the event the member is not eligible under the program(s) administered by CenCal Health, payment for any services provided to the member will not be the responsibility of CenCal Health.

Note: Pediatric members may be eligible for occupational therapy services through the CCS Medical Therapy Program (MTP). Please refer to <https://www.dhcs.ca.gov/services/ccs> for more information.

Treatment Plan (required for all members when requesting authorization)

The following must be present on the written treatment or prescription plan:

- Signature of the prescribing practitioner
- Name, address and telephone number of the prescribing practitioner
- Date of treatment or prescription plan
- Medical condition necessitating the service(s) (diagnosis)

- Supplemental summary of the medical condition or functional limitations
- Specific services (for example, evaluation, treatments, modalities) prescribed
- Frequency of services
- Duration of medical necessity for services – specific dates and length of treatment should be identified if possible. Duration of therapy should be set by prescriber
- Anticipated medical outcome as a result of the therapy (therapeutic goals)
- Date of progress review (when applicable)
- Age of member
- Mental status and ability to comprehend
- Related medical conditions
- Any delay in achievement of developmental milestones or impairment of normal achievement

The treatments or prescriptions must be realistically related to activities of daily living such as nutrition, elimination, dressing, and locomotion, in light of the patient's functional limitations. The specific goals of training or devices prescribed must also be indicated.

Documentation of Services

The Occupational Therapy provider shall document services by completing a claim form and submitting the form to CenCal Health. Occupational Therapy providers shall also provide documentation to the member's PCP.

Authorizations

Occupational Therapy providers are required to obtain a prescription from the member's PCP, or any qualified physician, for Occupational Therapy services provided to all members. Referral Authorization Forms (RAFs) are not required for services under any program. Additionally, all occupational therapy services require a Treatment Authorization Request (TAR) or an Authorization Request (AR) to be approved by CenCal Health. Please refer to the TAR/AR Sections of this Provider Manual for more information.

Specific Authorization of Occupational Therapy Services

For Occupational Therapy services which require prior authorization by CenCal Health, approval is limited to services which:

- Are necessary to prevent or substantially reduce an anticipated hospital stay
- Continue a plan of treatment initiated in the hospital
- Are recognized as a logical component of post hospital care

Billing for Covered Services

Occupational Therapy providers bill CenCal Health for the Occupational Therapy services he or she has provided to the eligible member. In the event the member has other coverage, or third-party liability is involved, the Occupational Therapy provider shall follow the terms and conditions of his/her Agreement with CenCal Health, or as indicated in "Other Health Coverage" in the Claims Section of this Provider Manual.

Occupation Therapy Services:

- Occupational Therapy providers shall bill using Provider's valid billing number
- The ICD-10-CM diagnosis code(s) of the member's condition must be on the claim
- If member's condition is related to employment, then CMS-1500 box 10a must be checked "YES";

Procedure Codes

SBHI & SLOHI - Allied Health Providers who have rendered Covered Services to eligible SBHI and SLOHI Members shall submit Claim forms within one (1) year of the date of service, in accordance with the provisions of Section 4.6 of the Agreement. However, Claims submitted after six (6) months will be reduced to 75% of the allowable, and those submitted after nine (9) months from the date of service will be reduced to 50% of the allowable.

Occupational Therapy Provider shall bill for services using procedure codes referenced in Title 22, CCR, §51507.1, Occupational Therapy, or as indicated in the EDS Medi-Cal Provider Manual.

SBHI & SLOHI Reimbursement for Occupational Therapy Services

Occupational Therapy Provider and its Subcontractors agree and understand that they will accept the State Medi-Cal rate in effect at the time of service, or CenCal Health's rate in effect at the time of service, whichever is higher.

Occupational Therapy Provider may request rate information for specified reimbursement codes for its specialty by contacting the Provider Services Department or a Claims Representative, or by accessing the Procedure Pricer on CenCal Health's website www.cencalhealth.org for rates and on the Medi-Cal website for Medi-Cal rates.

E2.20: Orthotics and Prosthetics

Orthotic and Prosthetic providers will be responsible for first determining the eligibility of members to receive services, for meeting the elements of and documenting services as indicated below, and in order to receive payment, for submitting claim forms to CenCal Health.

"Orthotist" shall mean a person who makes and fits orthopedic braces for the support of weakened body parts or the correction of body defects.

"Prosthetic and Orthotic Appliances" shall mean those appliances prescribed by a physician, dentist or podiatrist for the restoration of function or replacement of body parts.

"Prosthetist" shall mean a person who makes and fits artificial limbs or other parts of the body.

Eligibility

Orthotic and Prosthetic providers must confirm that the member presenting in his/her office is eligible for services under CenCal Health and is assigned to the referring PCP for the month in which he/she is to render services. This can be accomplished by verifying eligibility through one of CenCal Health's systems. Information regarding eligibility is in the Member Services Section of this Provider Manual.

In the event the member is not eligible under the program(s) administered by CenCal Health, payment for any services provided to the member will not be the responsibility of CenCal Health.

Orthotics & Prosthetics Benefit

Orthotics and Prosthetics benefits include original and replacement devices, including but not limited to the following:

- Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his/her licensure
- Medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his/her license
- Initial and subsequent prosthetic devices and installation of accessories to restore a method of speaking incident to a laryngectomy
- Therapeutic footwear for diabetics
- Prosthetic devices to restore and achieve symmetry incident to mastectomy

Non-Covered Items of Orthotics and Prosthetics

- Corrective shoes, shoes inserts and arch supports except for therapeutic footwear and inserts for individuals with diabetes
- Non-rigid devices such as elastic knee supports, corsets, elastic stockings and garter belts
- Dental appliances
- Electronic voice producing machines
- More than one device for the same part of the body

Documentation of Services

Orthotic and Prosthetic providers shall document services by completing a claim form and submitting the form to CenCal Health. Orthotic and Prosthetic providers shall also provide documentation to the member's PCP.

Authorizations

Orthotic and Prosthetic providers are required to obtain a referral for certain services prior to providing services in the form of a **prescription (Rx)** from the member's PCP. Prescription (Rx) forms are available through CenCal Health or the Medi-Cal website, www.medi-cal.ca.gov.

Additional authorization for DME products

Prior Authorization, in the form of a **Treatment Authorization Request (TAR)** for SBHI and SLOHI is required for the following conditions:

- **Orthotics** exceeding \$250.00 (cumulative in a 90 day period)
- **Prosthetics** exceeding \$500.00 (cumulative in a 90 day period)

Billing for Covered Services

Orthotic and Prosthetic providers bill CenCal Health, using provider's Medi-Cal provider number for SBHI and SLOHI, or the Tax Identification Number for HF, HK, PP2 and IHSS, for the Orthotic and Prosthetic services he/she has provided to the eligible member. In the event the member has other coverage, or third-party liability is involved, the DME provider shall follow the terms and conditions of his/her Agreement with CenCal Health, or as indicated in "Other Health Coverage" in the Claims Section of this Provider Manual.

Co-payments

No co-payments for Orthotics and Prosthetics are required for the following programs: SBHI or SLOHI; however, the IHSS program requires co-payments in the form of co-insurance.

Reimbursement for Orthotic and Prosthetic Covered Services

Provider shall be reimbursed by CenCal Health for Covered Services rendered to members as indicated in the Exhibit A of provider's Allied Amendment Agreement.

E2.21: Speech Therapy

Type of Services Provided

Services provided by Speech Therapy (or Speech Pathology) providers are covered for Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) members. Speech therapy services also include speech therapy evaluation, treatment planning, treatment, and consultations.

A member may access Speech Therapy services (ST) for the purpose of identification, measurement and correction or modification of speech, voice or language disorders and conditions, and counseling related to such disorders and conditions. The goal of therapy should be achievement of intelligibility rather than age-specific qualities or previous condition status, such as with a stroke victim.

Covered ST Benefits for SBHI and SLOHI

The following procedures are covered benefits:

- ST services are a covered benefit only when services are provided pursuant to a written treatment plan or written prescription of a CenCal Health physician, which is within the scope of his/her medical practice. See below for additional information on information needed on the prescription or written treatment plan
- ST services are only covered when care is rendered in the Provider's office, at home or in an outpatient department of a hospital facility. ST Services could also be done via telehealth.
- ST services must be performed by licensed and registered therapists or pathologists. However, licensed speech pathologists may be reimbursed for covered services performed by unlicensed speech pathologists working under their direct supervision to fulfill Required Professional Experience (RPE) for licensure
- ST services are also covered when the member is an inpatient at an acute care hospital, in a skilled nursing facility, or at a rehabilitation hospital

- ST for maintenance programs to preserve the member's present level of function is not covered by CenCal Health.

Speech Therapy Benefits for Children

Prior to providing speech therapy services to Members under the age of 21, please review the guidelines below to ensure the Member is receiving services through the appropriate agency:

- Under EPSDT regulations speech therapy is covered as long as the service is determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. Services to correct or ameliorate defects due to a developmental or neuro-developmental condition such as Autism Spectrum Disorder is therefore covered by CenCal. In order to prevent duplication of services provided by the LEA or under Early Start, CenCal will request verification of services provided by these entities.
- The CCS program covers ST services for children under the age of 21 when determined to be medically necessary to treat a CCS eligible medical condition.

Eligibility

Speech Therapy providers must confirm that the Member presenting in his/her office is eligible for services under CenCal Health and is assigned to the referring Primary Care Provider (PCP) for the month in which he/she is to render services. This can be accomplished by verifying eligibility through one of CenCal Health's systems.

In the event the Member is not eligible under the program(s) administered by CenCal Health, payment for any services provided to the Member will not be the responsibility of CenCal Health.

Authorizations

Speech Therapy providers are required to obtain a prescription from the Member's PCP, or any qualified CenCal physician, for Speech Therapy services provided to all Members. Referral Authorization Forms (RAFs) are required for speech therapy services. Additionally, submission of Treatment Authorization Requests (TAR) is required for initial evaluations and for subsequent follow-up visits for CenCal Health Members.

Treatment Plan (required for all members when requesting authorization)

The following must be present on the written treatment or prescription plan:

- Signature of the prescribing practitioner
- Name, address and telephone number of the prescribing practitioner
- Date of treatment or prescription plan
- Medical condition necessitating the service(s) (diagnosis)
- Supplemental summary of the medical condition or functional limitations
- Specific services (for example, evaluation, treatments, modalities) prescribed
- Frequency of services
- Duration of medical necessity for services – specific dates and length of treatment should be identified if possible. Duration of therapy should be set by prescriber
- Anticipated medical outcome as a result of the therapy (therapeutic goals)
- Date of progress review (when applicable)

- Age of member
- Developmental status and rate of achievement of developmental milestones
- Mental status and ability to comprehend
- Related medical conditions

Specific Authorization of Speech Generating Devices

Information regarding Speech Generating Devices (SGDs), including Authorization requirements, is set forth below in this document.

Billing for Covered Services

Speech Therapy providers bill CenCal Health for the Speech Therapy services he or she has provided to the eligible Member. In the event the member has other coverage, or third-party liability is involved, the Speech Therapy provider shall follow the terms and conditions of his/her Agreement with CenCal Health, or as indicated in "Other Health Coverage" in the Claims Section of this Provider Manual.

Speech Therapy Services:

- Speech Therapy providers shall bill using Provider's valid billing number
- The ICD-10-CM diagnosis code(s), or appropriate successor code set, of the member's condition must be on the claim
- If member's condition is related to employment, then CMS-1500 box 10a must be checked "YES";
- box 10b must be checked "YES"

SBHI & SLOHI - Allied Health Providers who have rendered Covered Services to eligible SBHI and SLOHI Members shall submit Claim forms within one (1) year of the date of service, in accordance with the provisions of Section 4.6 of the Agreement. However, Claims submitted after six (6) months will be reduced to 75% of the allowable, and those submitted after nine (9) months from the date of service will be reduced to 50% of the allowable.

Procedures Codes

Speech Therapy Provider shall bill for services using procedure codes referenced in Title 22, CCR, §51507.1, Speech Therapy, or as indicated in the EDS Medi-Cal Provider Manual.

Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Billing Codes. Allied Health Provider shall bill for services for HK and AIM Members within the acceptable range of CPT and/or HCPCS billing codes as established in the most recently published American Medical Association's (AMA) CPT guide and/or the HCPCS guide as published by the federal Department of Health and Human Services (HHS).

SBHI & SLOHI Reimbursement for Speech Therapy Services

Speech Therapy Provider and its Subcontractors agree and understand that they will accept the State Medi-Cal rate in effect at the time of service, or CenCal Health's rate in effect at the time of service, whichever is higher.

Speech Therapy Provider may request rate information for specified reimbursement codes for its specialty by contacting the Provider Services Department or a Claims

Representative, or by accessing the Procedure Pricer on CenCal Health's website www.cencalhealth.org for CenCal Health rates and on the Medi-Cal website for Medi-Cal rates.

Speech Generating Devices (SGDs)

SGDs are electronic voice producing systems that correct expressive communication disabilities that preclude effective communication. Effective communication is defined as the Member's most appropriate form of communication, allowing meaningful participation in daily activities. The HCPCS codes for SGDs require prior authorization. Prior authorization must be obtained for both purchase and rental of an SGD. If SGD is billed "By Report", a copy of the relevant page(s) of the manufacturer's catalog must be attached in order to receive reimbursement. The rental of an SGD will only be allowed if the Member's SGD is being repaired or modified, or if the Member is undergoing a limited trial period to determine appropriateness and ability to use the SGD. Purchase of an SGD must be billed with modifier NU and the rental of an SGD must be billed with modifier RR. A repair of an SGD should be billed with the appropriate SGD HCPCS code for the part repaired followed with modifier RP.

Authorization of the SGD

An Authorization Request requires all of the following documentation:

- Recipient Assessment
 - medical diagnosis and significant medical history,
 - visual, hearing, tactile and receptive communication impairments or disabilities, and their impact on the recipient's expressive communication, including speech and language skills and prognosis,
 - current communication abilities, behaviors and skills, and the limitations that interfere with meaningful participation in current and projected daily activities,
 - motor status, optimal positioning, and access methods and options, if any, for integration of mobility with the SGD,
 - current communication needs and projected communication needs within the next two years,
 - communication environments and constraints that impact SGD selection and features,
 - any previous treatments of communication problems, responses to treatment, and any previous use of communication devices,
- Summary of Requested SGD
 - vocabulary requirements,
 - representational systems,
 - display organization and features,
 - rate of enhancement techniques,
 - message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory visual output, programmability, input modes and their appropriateness for use by the specific recipient,
 - portability and durability, and adaptability to meet anticipated needs,
 - identity, significant characteristics and features,
 - manufacturer's catalog pages, including cost (for "By Report" SGDs),

- any trial period when the recipient used the recommended device(s) in an appropriate home and community-based setting that demonstrated the recipient is able and willing to use the device effectively,
 - an explanation of why the requested device(s) and services are the most effective and least costly alternative available to treat the recipient's communication limitations,
 - whether rental or purchase of the device is the most cost-effective option, vendors,
 - warranty and maintenance provisions available for the device(s) and services
- Treatment Plan
 - the expected amount of time the device will be needed, and the amount, duration and scope of any related services requested to enable the recipient to effectively use the device to meet basic communication needs,
 - short-term communication goals,
 - long-term communication goals,
 - criteria to be used to measure the recipient's progress toward meeting both short-term and long-term goals,
 - identification of the services and providers (and their expertise and experience in rendering these services)

Benefit Limitation for SGDs

SGD rental is limited to approval only when the Member is undergoing a trial period to determine appropriateness and ability to use an SGD or if the member's SGD is being repaired or modified.

E2: Limited Services

Limited Services are restricted benefits for SBHI and SLOHI members. Limited Service for adult members include, but are not limited to Audiology, and Chiropractic Services, which are subject to a maximum of two services per month or combination of two (2) services per month.

Occupational Therapy, Speech Therapy, and Physical Therapy Services (for children under EPSDT regulations, OT, SP & PT services may not have limits. Limits must only be based on medical necessity criteria) are subject to a maximum of eighteen (18) services per year. Additional services may be provided based upon medical necessity through the TAR process. For further instructions on TAR's, please refer to Section **H3: Request for Authorization** of the Provider Manual.

Eligibility

- The Provider will be responsible for verifying that the recipient is eligible with CenCal Health for the date of service. Eligibility can be verified through via the [Provider Portal](http://www.cencalhealth.org) at www.cencalhealth.org.

Billing for Covered Services

- For billing questions please refer to **K1: Claims Billing** of the Provider Manual or reference the [Medi-Cal site](#) for details on covered services.

Authorizations:

“Medi-Reservation” shall mean a method of limiting the Medi-Services (or “Limited Services”) allowed under the Medi-Cal program, whereby a Member is entitled only to two visits or services per month. Please refer to Section **H5: Medi-Reservations** of the Provider Manual.

E3: Adult Preventive Services

CenCal Health promotes all preventive health services for adults in accordance with the most recent United States Preventive Services Task Force (USPSTF) “[Guide to Clinical Preventive Services](#).” Additionally, CenCal Health promotes immunization recommendations for adult Members in accordance with the most recent Centers for Disease Control and Prevention (CDC) “[Recommended Immunization Schedule for Adults aged 19 Years or Older](#).” CenCal Health requires Primary Care Physicians or Advanced Practice Providers to make available this core set of preventive services consistent with the USPSTF and CDC. Copies of these guidelines are available from CenCal Health upon request. Both documents are on CenCal Health’s, [Quality of Care section](#), Preventive Health Guidelines page.

Preventive services shall include all medically necessary and age appropriate screenings recommended by the USPSTF and/or CDC, including but not limited to:

- Immunizations
- Screenings for hypertension, cholesterol, depression, tobacco cessation, substance use and cancer screenings
- Laboratory tests
- Adverse Childhood Experiences (ACE) Screening (new 2020)

Assessment of medically necessary preventive services may be done at any opportunity, but at least annually during Initial and Periodic Preventive Medicine Evaluation visits. Preventive Medicine Evaluations are CenCal Health benefits and are paid on a fee-for-service basis. Reimbursement rates for Preventive Medicine Evaluations are set forth in the Agreement in Exhibit A, Section 5.6. CPT codes for these Preventive Medicine Evaluation visits are: 99385-99387 for new patients, and 99395-99397 for established patients. Most routine screenings performed by primary care practitioners (i.e. visual acuity screening) are included in the Preventive Medicine Evaluation exam and are not separately billable. If uncertain, to verify whether a particular screening test is separately billable, please contact your CenCal Health Claims Representative.

CenCal Health updates and publishes the Preventive Health Guidelines (PHG) annually in the *Your Health/Su Salud* member newsletter. CenCal Health’s Member Services Department sends the PHG documents to new members and conducts outreach to adult Members due for a preventive healthcare visit.

New Members are also encouraged to make an appointment for a Preventive Medicine Evaluation, otherwise known as an Initial Health Assessment (IHA) within 120 days of enrollment. For adult Members, the IHA follows the requirements of the Health and Safety Code, Sections 124025, and following, and Title 17, CCR, Section 6842 through 6852.

URLs for above hyperlinks:

CenCal Health Preventative Health Guidelines For Adults (English/Spanish Handout)
<https://www.cencalhealth.org/~media/files/pdfs/health/hw2018preventiveadult.pdf?la=en>

Centers for Disease Control and Prevention (CDC) Immunization Schedule for Adults aged 19 Years or Older
www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf

CenCal Health Quality of Care
[Quality of Care | CenCal Health Insurance Santa Barbara and San Luis Obispo Counties](#)

E4: Pediatric Preventive Services

CenCal Health promotes all preventive health services for children in accordance with the most recent American Academy of Pediatrics (AAP) "[Recommendations for Pediatric Preventive Health Care](#) (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)." Immunization recommendations for all Members are in accordance with the most recent "[Recommended Immunization Schedule for Children and Adolescents](#)" approved by the Advisory Committee on Immunization Practices (ACIP). Both documents are on CenCal Health's website at cencalhealth.org/providers/quality-of-care/clinical-guidelines/.

Preventive services shall include all medically necessary and age appropriate screenings recommended by the AAP and/or ACIP including but not limited to:

- Health and developmental history, including assessment of both physical and mental health development
- Physical examination
- Oral health assessment (dental screening) and referral; including fluoride varnish application in PCP office
- Assessment/discussion of BMI percentile, nutritional status, and physical activity
- Screenings appropriate to age, including but not limited to tests for vision, hearing, dyslipidemia, depression, and adverse childhood experiences. Completion and review of a [Staying Healthy Assessment](#) (SHA)
- Immunizations
- Laboratory tests, including but not limited to tests for anemia, diabetes, lead exposure, tuberculosis, and urinary tract infections
- Health education and anticipatory guidance appropriate to age, including but not limited to counseling about nutrition and physical activity

PCPs should bill for preventive services using standard claim forms. Preventive Medicine Evaluations for pediatric members are covered by CenCal Health. The CPT codes for Preventive Medicine Evaluation visits for children are: 99381-99385 for new patients, and 99391-99395 for established patients. Most routine screenings performed by primary care practitioners (i.e. visual acuity screening) are included in the preventive care exam and are not separately billable. To determine whether a

particular screening is separately billable, please contact your CenCal Health Claims Representative.

CenCal Health updates and publishes the Preventive Health Guidelines (PHG) annually in the *Health Matters/Temas de Salud* member newsletter. CenCal Health's Member Services Department sends the PHG documents to new members and conducts outreach to encourage Preventive Medicine Evaluations for all pediatric Members due for preventive healthcare visits.

New Members are also encouraged to make an appointment for a Preventive Medicine Evaluation, otherwise known as an Initial Health Assessment (IHA) within 120 days of enrollment. For more information about IHAs, refer to section **Error! Reference source not found.** of the manual.

E5: Child Health and Disability Prevention (CHDP) Program

Child Health and Disability Prevention (CHDP) program is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP administers the federally mandated "California's version of the Federal Early Periodic Screening, Diagnosis and Treatment (EPSDT)" benefit of the Medi-Cal program for individuals under the age of 21.

The County CHDP program covers members from birth up to 21 years of age who are enrolled in the Medi-Cal Gateway program or have no health coverage.

CenCal Health is directly responsible for paying providers for Medi-Cal services covered under federally mandated EPSDT services not already paid for through the CHDP program for CenCal Health members.

All billing for CHDP services, is to be billed directly to CenCal Health for CenCal Health members. Claims submitted by a provider who is not contracted with CenCal Health will be denied payment for the CHDP services provided. We encourage providers to initiate a contractual relationship with CenCal Health. If you have any questions, please call CenCal Health Provider Services Line at (805) 562-1676.

Provider Participation Requirements

Although the CHDP program is administered by the County Children's Medical Services Department and is separate from CenCal Health, CenCal Health Primary Care Providers who see CHDP eligible members are encouraged to consider participating in this program. Members with suspected problems are referred for necessary diagnosis and treatment. The earlier they are identified, the faster they can be treated and more serious problems can be prevented. It is important to note that CHDP providers are reimbursed for the exams in addition to the monthly capitation the PCP receives from CenCal Health.

The PCP is responsible for the primary care case management, coordination of medical referrals, and the continuity of care for members qualified to receive CHDP services.

PCP is also responsible for the following activities:

- Assist with scheduling medical appointments.
- Following up on missed appointments,

- Referring children to the County CHDP Program who have lost Medi-Cal eligibility and CenCal Health benefits but who still require treatment.
- CHDP services provided by a provider other than the assigned PCP will require a RAF for payment.
- Referring members who are potentially eligible for community resources to such local resources.
- Referring children with a possible mental health diagnosis (excluding Autism Spectrum Disorder) to County Mental Health for assessment and treatment services under EPSDT regulations.
- Referring children with developmental delays for assessment and treatment services under EPSDT regulations. Referrals may include an evaluation to a licensed psychologist for evaluation of a possible diagnosis of Autism Spectrum Disorder and referrals to treatment services including but not limited to Occupational Therapy, Speech Therapy, Physical Therapy and Behavior Intervention Services.

Training and education for the PCPs on CHDP program related issues and standards will be provided by both the County and CenCal Health.

Additionally, CHDP Providers are defined as "providers of medical services who have applied to and have been approved by Santa Barbara or San Luis Obispo County's CHDP Program and agree to provide CHDP services according to the CHDP Health Assessment Guidelines and the CHDP Program regulations in the Health and Safety Code, Section 124025.

CenCal Health assumes administrative responsibility for the CHDP program while Santa Barbara and San Luis Obispo counties ("the County") will retain the authority to recruit, certify, and re-certify CHDP Providers and to monitor their compliance."

URLs for above hyperlinks:

Bright Futures Periodicity Schedule

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

E6: Behavioral Health Treatment

CenCal Health covers Behavioral Health Treatment (BHT) for individuals under the age of 21 in accordance with DHCS EPSDT guidelines. Behavioral Health Treatment services may include but is not limited to Applied Behavior Analysis (ABA), behavioral interventions and parent training.

A member may qualify for Behavioral Health Treatment Services if all of the following criteria are met:

- The member is under 21 years of age
- The member has Medi-Cal as primary insurance
- The member is presenting with a pattern of developmentally inappropriate behaviors that is significantly affecting their ability to function in the community and at home. Please note CenCal covered BHT services do not address behaviors affecting the member's functioning in the primary academic educational setting as outlined in an Individualized Education Plan (IEP)
- The behaviors are not a result of an untreated medical condition, sensory impairment or mental health disorder that can be treated with another

- modality (i.e. speech therapy, physical therapy, occupational therapy, counseling services or medication) or the behaviors can be further treated or ameliorated by the provision of BHT in addition to existing treatment modalities
- The member is medically stable
 - The member is not in need of a 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities
 - BHT services are medically necessary and are recommended by a licensed physician, surgeon or clinical psychologist.

Medical Necessity

Medical necessity is defined by state and federal law as a service that is necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions. For children diagnosed or suspected to suffer from an autism-spectrum disorder or other related health conditions, medical necessity is therefore directed to prevent or minimize the adverse effects of behaviors that are a result of their neuro-developmental disorder and to promote to the extent practicable, the functioning of members.

The following BHT services are not covered by CenCal health as outlined in Medi-Cal All Plan Letter 19-014:

- Services rendered when continued clinical benefit is not expected, unless the services are determined to be medically necessary.
- Provision or coordination of respite, day care or custodial care or to reimburse a parent, legal guardian or legally responsible person for costs associated with participation under the Behavioral Health Treatment plan.
- Treatment where the sole purpose is vocationally or recreationally based.
- Custodial care. For purposes of BHT services, custodial care:
 - a. Is provided primarily to maintain the member's or anyone else's safety; and,
 - b. Could be provided by persons without professional skills or training.
- Services, supplies, or procedures performed in non-conventional setting, including, but not limited to, resorts, spas, and camps.
- Services rendered by a parent, legal guardian, or legally responsible person.
- Services that are not evidence-based behavioral intervention practices.

Referral process

Accessing & referral process

Behavioral Health Treatment services and Psychological Testing, used to complete a comprehensive assessment, require a pre-authorization. Time-lines for authorization of treatment services are in accordance with standard Medi-Cal guidelines as described in **Section H: Referrals and Authorizations** of the Manual.

Primary care providers and specialists, including clinical psychologists, developmental behavioral pediatricians and pediatric neurologists, who believe that a CenCal member meets medically necessary criteria for BHT services, can submit a referral (RAF) via the CenCal portal or by fax at (805) 681-3070 to the Behavioral Health Department providing the following supporting documents:

- Copy of a comprehensive developmental assessment completed in the past 2 years that provides a treatment recommendation that BHT services are

- medically necessary and clinically appropriate. Comprehensive assessments completed by an out-of-network clinical psychologist or developmental behavioral pediatrician including a provider contracted by Regional Center will be accepted. Assessments completed by an Educational Psychologist as part of an evaluation for an IEP or IFSP may be provided in addition to required assessment documentation.
- Medical documentation to confirm that the member is medically stable and able to participate in services and that the member's behaviors are not due to an untreated medical condition.
 - Supportive documentation providing information on the targeted behaviors that the member is exhibiting that is impairing the member's functioning at home and/or the community and a recommendation that the member will benefit from BHT services.
 - Providers that need a comprehensive assessment to be completed, can submit a referral (RAF) to the CenCal BH Department via the Provider portal or by fax to the Behavioral Health Department at (805) 681-3070, please use the Behavioral Health fax sheet.

Time-lines for authorization of treatment services are in accordance with standard Medi-Cal guidelines as described in **H7: Timeliness for Authorization Request** of the Manual.

Provider Expectations

BHT services covered by CenCal Health must be an evidence-based intervention identified by the National Standards Project (2015) or by the National Clearinghouse on Autism Evidence & Practice (2020). For all BHT services, the following elements are required and covered by CenCal.

Functional Behavioral Analysis (FBA) and Initial Treatment Plan

- Members that meet eligibility criteria for BHT services will be authorized by CenCal for a FBA and development of a treatment plan by a contracted BHT provider.
- BHT Providers are expected to offer members an initial appointment within 10 business days after the approval of the FBA. Providers will be expected to report to CenCal as part of the FBA report, the date of the 1st appointment offered, date of 1st appointment scheduled and reason for difference between offered and scheduled appointments.
- Providers must document all outreach efforts to the parents to schedule the initial appointment. Providers that are unable to schedule referred members within 30 calendar days or unable to reach parents or legal guardians within 30 calendar days, are requested to refer the member immediately back to CenCal.
- CenCal Health will pre-authorize a pre-determined number of units of H0031 for purposes of the FBA (both direct and indirect services). The authorization will be issued for 60 calendar days.
- Providers that require additional units or an extension to the approved time period, must submit a TAR with justification to the BH Program via the Provider Portal or by fax to the Behavioral Health Department at (805) 681-3070.

- Upon completion of the FBA assessment, the BHT provider will submit a Treatment Authorization (50-1) to CenCal requesting authorization for services for up to 6 months. BHT providers will upload a copy of the FBA report with the authorization request through the Provider Portal or fax to the Behavioral Health Department at (805) 681-3070. The FBA results must be reported on the required template provided to providers. BHT providers are expected to initiate services within 10 business days after CenCal authorizes services.
- BHT Providers requesting only Social Skills treatment should submit the Social Skills Template with the Treatment Authorization (50-1) through the Provider Portal or fax to the Behavioral Health Department at (805) 681-3070.

BHT treatment services

- BHT providers will deliver treatment services according to the approved treatment plan. Services include direct intervention, supervision, caregiver training and social skills training.
- Credible studies and industry standards support that parent participation is associated with improved outcomes. Providers are responsible to coordinate parent participation as appropriate with treatment planning and service delivery.
- Some portions of direct services may be provided in the school setting when behavioral or other difficulties are evident. Goals and objectives may however not be related to academic functions. If services at a school setting is requested, providers or parents/guardians must provide to CenCal Health a copy of the most recent IEP to provide evidence that the services requested are not duplicative to services provided under the IEP. In addition documentation must be provided that the school district has approved that the requested services may be provided on the school grounds and the times that the BHT provider is allowed to provide the services. Services in the school setting will not be approved until the necessary documentation is provided
- Group treatment is covered only for social skills groups and provided by non-paraprofessional staff. Credible studies have demonstrated that ABA services are most effective when consisting predominantly of individual and family treatment. Individual treatment when the member is in a group setting is covered only when the clinical staff is working exclusively with the member for the entire time that the member is in the group setting.
- The following activities and therapy modalities that do not constitute behavioral assessments and interventions utilizing ABA techniques will be considered non-covered services. Examples include (but are not limited to):
 - Training of staff
 - Preparation work prior to the provision of services
 - Accompanying the client to appointments or activities (i.e. shopping, medical appointments) except when the identified client has demonstrated a pattern of significant behavioral difficulties during specific activities, in which case the clinician to actively provide treatment, not to just supervise, control, or contain the member/identified client.
 - Transporting the member/identified client in lieu of parental transport. If the member/identified patient has demonstrated a pattern of significant

behavioral difficulties during transport, in which case transport is still provided by the parent, and the clinician is present to actively provide treatment to the member/identified client during transport, not to just supervise, control, or contain the member/identified client.

- Assisting the member with academic work or functioning as a tutor, or functioning as an educational aide for the member/identified client in school/daycare or at home.
- Provision of services that are part of an IEP and therefore should be provided by school personnel.
- Provider travel time
- Transporting parents or other family members
- 14 days prior to end of the authorization period, providers should submit an authorization request 50-1 with a progress note using the prescribed template and service logs
- Providers are required to consider the member's age, availability of family for services, member's school attendance requirements, participation in medical treatment services such as speech therapy or occupational therapy and any other daily activities when determining the number of hours of medically necessary services.
- Providers are expected to account for provision of services that are less than hours approved by CenCal.

Graduation and fading of services

- BHT services must be faded gradually and systematically over time as the member meets treatment goals or the member has met maximum benefit of services. BHT providers will complete a discharge summary and submit to CenCal Health BH Department.
- Members who turn 20 while receiving BHT services, must commence fading of services plan in order to graduate prior to their 21st birthday. BHT providers will work closely with the CenCal BH Department to facilitate member's transition from EPSDT services.

Coordination of Care

Behavioral Health Treatment Providers are responsible to coordinate care with the primary care physician, other providers and entities closely involved with the member's care. Coordination of care activities may include the following:

- Contacting member's pediatrician if member may benefit from other therapies such as Occupational Therapy, Speech Therapy, or comprehensive medical case management.
- Working closely with all other providers such as regional center and the Local Education Agency.
- Contacting the CenCal Health Behavioral Health Department to consult on complex cases or barriers to service delivery i.e. homelessness, unsafe home-environment, lack of staff, etc.

Claims

- BHT providers will only use the procedure codes and modifiers listed below. Except when otherwise directed by CenCal, in-network providers must use the codes listed in this section in order to be reimbursed for BHT services.
- Direct supervision can be claimed at the rate of two hours for every 10 hours of direct treatment.
- Assessments for the purpose of the FBA (H0031) are allowed at the initiation of services. In the event of a disruption of BHT services lasting 4 or more months, CenCal will approve another FBA again. Paraprofessional's time in supervision is not a covered service because the service being provided (supervision) is being delivered by the BHT professional. The exception will be when the BHT professional is supervising the paraprofessional while the latter is providing covered direct treatment services. Coverage will only be for the time that the direct services is provided by the paraprofessional and the BHT professional staff is providing supervision.
- The following are considered unnecessary duplication of services and therefore not medically necessary in the provision of BHT services. Exceptions will be considered however based on the individual needs of the member.
 - More than one professional or para-professional for an identified client
 - More than one provider group providing BHT services at any one time

HCPCS Codes	Description
H0031 per hour	Assessment
H0032 per hour	Treatment Plan development (including supervision)
H2014 per 15 min	Skills Training and development (group)
H2019 per 15 min	Therapeutic Behavioral Services
S5111 per session	Home care/family training

Documentation

FBA's and progress reports will be completed using the templates provided by CenCal Health. Providers will submit copies of service logs when submitting authorization requests. Not using the prescribed templates or incomplete reports will result in a delay in authorization of services.

Behavioral Treatment Plan Requires:

The behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific member being treated. Providers should refrain from "copy/paste" goals across treatment plans.

The behavioral treatment plan must be reviewed, revised, and/or modified no less than every six months. The behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer medically

necessary under EPSDT medical necessity standards. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary.

The FBA/treatment plan must meet the following criteria:

- 1) Include a description of patient information, reason for referral, brief background information, clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
- 2) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
- 3) Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant and based upon clinical observation.
- 4) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
- 5) Include the member's current level of need (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria, date of introduction, estimated date of mastery, specific plan for generalization and report goal as met, not met, modified (include explanation).
- 6) Utilize evidenced-based BHT services with demonstrated clinical efficacy tailored to the member.
- 7) Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services.
- 8) Include care coordination that involves the parents or caregiver(s), school, state disability programs, and other programs and institutions, as applicable.
- 9) Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours that are medically necessary direct service and supervision.
- 10) Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community.
- 11) Include an exit plan/criteria.

E7: Mental Health Services

Mental health services are a covered benefit for CenCal Health members when medically necessary and may be or a provider contracted with CenCal.

CenCal Health covers services for adults (age 21 and older) presenting with a mental health diagnosis according to the DSM V that is resulting in mild to moderate impairment of mental, emotional, or behavioral functioning. Medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or disability or to alleviate severe pain through the diagnosis and treatment of the illness.

For children and young adults under the age of 21, CenCal Health is responsible for providing medically necessary non-specialty mental health services.

Types of Services Provided:

The following Mental Health services covered by CenCal Health include:

- Initial evaluation to establish medical necessity (does not require a pre-authorization)
- Individual, family and group mental health evaluation and treatment (psychotherapy) (does not require a pre-authorization)
- Psychological testing, when clinically indicated to evaluate a mental health condition or establish diagnosis for a neuro-developmental condition (Requires pre-authorization)
- Outpatient services for the purposes of monitoring drug therapy (does not require a pre-authorization)
- Outpatient laboratory, drugs, supplies and supplements (does not require a pre-authorization)
- Psychiatric consultation to a member to establish medical necessity for medication management of a psychiatric or behavioral disorder (No pre-service authorization required. Treating physician must be the requesting provider. Note: psychiatric consultation in the Emergency Room is not a covered benefit).
- Preventative family therapy services for pediatric members under the age of 21 with elevated Adverse Childhood Experience (ACE) scores who are not presenting with a diagnosable mental health condition.

There are no defined limits on the number of visits a member can have with a mental health professional. Providers are expected to ensure the frequency of services and treatment plan are in line with the treatment of with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), that results in mild to moderate distress or impairment of mental, emotional or behavioral functioning.

Benefits will be arranged and provided based upon medical necessity and the level of care needed to make progress towards treatment goals.

Exclusions: Couples counseling or family counseling to address relational problems are not covered.

Specialty Mental Health Services (including crisis response, inpatient and residential treatment and mental health services to children under EPSDT) will continue to be the responsibility of the County Mental Health Departments. See Section F2 for more information on the criteria for specialty mental health services. County Mental Health Departments are available for psychiatric consultations to CenCal contracted primary healthcare providers.

Medical Necessity Criteria

- CenCal Health provides non-specialty mental health services for children and adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), that results in mild to moderate distress or impairment of mental, emotional or behavioral functioning.

- Medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or disability or to alleviate severe pain through the diagnosis and treatment of the illness.
- CenCal Mental Health services for the adult population group include all diagnosis DSM V diagnosis as primary focus of treatment **except** diagnoses related to substance use or dependence. (ICD 10: F10 –F 19).
 - Substance use and dependence disorders can be a secondary diagnoses to a primary mental health diagnosis for treatment purposes. Treatment for primary substance use disorders are carved-out to County Substance Abuse Services.
- Medication management providers may manage medication assistance treatment (MAT) options in conjunction with medications for mental health treatment, but may not only be solely providing MAT services to a member.

Authorizations & Referral Protocols

- Authorizations are not required for psychotherapy or medication management services or related services.
- CenCal and the Behavioral Health departments of SLO & SB County has a “No wrong door” practice for mental health referrals.
- Referrals (RAF) are required for psychological and psychological testing. The Member’s Primary Care Physician (PCP) can submit referrals via the Provider Portal or by fax to the Behavioral Health Department at (805) 681-3070.
- Members can self-refer or be referred by a provider to either contacting the CenCal Behavioral Health Care Coordination Center or the County Access line to request mental health services.
- Members may also contact a contracted mental health directly to schedule an initial assessment appointment for psychotherapy or medication management services. A listing of contracted mental health providers can be obtained on the CenCal website.
- To facilitate collaborative services between healthcare providers and mental health providers, providers should obtain a signed release of information for all other providers as clinically appropriate.
- In order to avoid duplication of services, providers should ensure that member is not receiving services at the County Department of Behavioral Health. If the member is receiving any services with the County Department of Behavioral Health including Substance Use, please consult with CenCal Department of Behavioral Health before proceeding with treatment.
- Primary Care Physicians who determine a member with positive scores on any substance use, mental health or ACE screening can refer the Member for the mental health services by submitting a referral (RAF) through the Provider Portal or by fax to the Department of Behavioral Health (805)681-3070. The Behavioral Health Department will outreach member to facilitate access to appropriate level of care.

CenCal Contact Numbers

CenCal Health Behavioral Health Department: 1 (877) 814-1861, fax number: (805)681-3070

Santa Barbara County Department of Behavioral Wellness

Access Line (24/7) (888) 868-1649

Psychiatry Consultation Services: 1-805 681-5103

San Luis Obispo Department of Behavioral Health
Access Line (24/7) (800) 838-1381
Psychiatry Consultation Services: (805) 781-4719

Provision of Mental Health services to CenCal members

Pursuant to the terms of the provider agreement, participating providers will provide covered mental health services to CenCal members

- In the same manner as services rendered to other clients/patients
- In accordance with accepted medical and mental health standards and all applicable state and/or federal laws, rules, and/or regulations In a quality and cost-effective manner
- Ensure that a member is not receiving county mental health services at the same time as receiving services under CenCal coverage, unless it is during a transition period
- Update member demographic, office and/or participating provider profile information promptly and in advance
- Notify CenCal BH Department of any members who require care management services
- Refer members to other participating providers when alternative or different mental health services are required
- Obtain a Release of Information and coordinate care with a member's other health/medical care providers as it support treatment collaboration
- Provide continuous care to a member who requires a County level mental health services until such time as the member is successfully transitioned to County-level services

Initial Psychosocial Assessment

CenCal Health requires that all new Members have an initial psychosocial assessment that includes a Level of Care screening that is completed during initial encounter(s) with their mental health treatment provider. A secondary initial psychosocial assessment is allowable during the calendar year for the purpose of re-assessing current functioning, re-assessing diagnosis, evaluating current level of care and updating member's treatment plan.

An initial psychosocial assessment enables the provider to assess the immediate needs, level of impairment (mild/moderate/severe), and develop a person-centered treatment plan to maintain and/or improve functioning.

Assessment Requirements

- **Psychosocial assessments.** Psychosocial assessment must include the following information
 - a. Presenting concerns
 - b. Medical history
 - c. Psychiatric history
 - d. History of trauma
 - e. Substance use history

- f. Developmental history (children and adolescents)
- g. Allergies/adverse reactions
- h. Current and past Medications
- i. Risk assessment
- j. Mental status exam
- k. Member strengths
- l. Cultural factors
- m. Diagnosis validated by clinical data
- n. Treatment plan and recommendations including completion of CenCal Level of Care screening instrument

Treatment Plan Requirements

- A **treatment plan** must be developed for each new episode and are updated as needed to reflect changes/progress of the member. CenCal BH Department recommends that treatment plan be updated every 6 months for psychotherapy services and annually for medication management services.
- Treatment plans must be consistent with diagnoses, have specific, measurable, attainable goals and estimated timeframes for goal attainment or problem resolution.
- The member's participation and understanding of the treatment plan must be documented.
- Informed consent for all medications must be clearly documented including a review of adverse effects of all prescribed medication including potential withdrawal symptoms if the medication is discontinued.
- Should also include crisis planning for the member as clinically indicated.

Progress Notes Requirements

- Progress Notes should include what psychotherapy interventions were used, and how they benefited the member in reaching his/her treatment goals.
- Medication management providers must indicate in each record what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.

Coordination of Care

- Mental Health providers are required to coordinate and direct appropriate care for members including:
 - a. Obtaining a signed release for PCP to coordinate care as necessitated.
 - b. Facilitate access to appropriate frequency of sessions as indicated on the member's initial psychosocial assessment and treatment plan.
 - c. Provide crisis support to member including directing member to Emergency Department or County Crisis Response team for further evaluation.
 - d. Coordinate care by:
 - i. Contacting the PCP for any medical needs or authorization requests.

- ii. Contacting the CenCal Health Behavioral Health Department to consult or request support/guidance to coordinate transferring member's care to the County Department of Behavioral Health.
- e. Provide coordination of mental health services, mental health referrals, ongoing assessment/monitoring of appropriateness of services to meet the needs of the member.
- f. Identifying all providers/participating providers involved in medical and/or behavioral health care and treatment of a member.
 - i. Mental Health providers should coordinate the delivery of care to the member with these providers/participating providers by obtaining required consent and authorization from the member and documenting accordingly in the member treatment record.

Discharge Planning

- Mental Health providers are required to collaboratively plan with Member and other providers as clinically indicated in the discharge plan. The following information must be documented:
 - a. Discharge date
 - b. Discharge summary and clinical recommendations

Billing

Providers are expected to adhere to billing requirements stipulated by the Medi-Cal Provider Manual. CenCal BH Department and Provider Services Department will send information on changes or updates on a regular basis and providers are welcome to contact either departments with any questions.

Providers are expected to use appropriate codes, based on patient care timeframes

Psychiatric Diagnostic Procedures

90791	Psychiatric Diagnostic Evaluation without medical services
90792	Psychiatric Diagnostic Evaluation with medical services

Psychiatric Diagnostic Interviews are reported one per day per provider, per member. Providers will submit claims using this code for the initial session with members, except non-physician providers who serve children under the age of 21 who may provide up to five (5) sessions of individual or family therapy without a DSM V primary diagnosis. Every time a member changes providers, the new provider is allowed to claim for a new assessment encounter

Providers can submit claims for these CPT codes when a member has a break in treatment of more than six months with the same provider or after a significant change in presentation or after a member was admitted to a psychiatric in-patient facility. Providers will complete a level of care screening each time that a claim for 90791 or 90792 is submitted.

There are no diagnostic limitation when submitting claims with the above CPT codes.

Interactive Complexity (CPT 90785)

This is an add-on code that can be billed with 90791, 90792, any individual psychotherapy codes (90832 – 90839), group psychotherapy (90853) or medication management services. The add-on code may be used in the following circumstances:

- when there are specific communication difficulties present i.e. high anxiety, high reactivity, parent disagreement/behaviors during session)
- evidence/disclosure of a sentinel event and mandated report to a third party
- Use of play equipment, physical devices, interpreter or translator services to overcome significant language barriers.

The conditions necessitating billing the add-on code must be clearly described in the progress notes.

90785 may not be used for biofeedback services.

Individual Therapy

Individual therapy can be provided and is reimbursable to adults and children with a mental health condition. The following diagnosis are excluded for individual & Group Therapy Services

F10 –F19 as a primary diagnosis (substance abuse),

F72 & F73 Severe and Profound Intellectual Disability (primary or secondary diagnosis)

Moderate to Severe Neurocognitive Disorders (i.e. Alzheimer's, Traumatic Brian Injury) (primary or secondary diagnosis)

*Children under the age of 21 are entitled to five sessions of individual or group therapy prior to being diagnosed with a mental health condition

Individual therapy is limited to a maximum of one and one-half hours per day by the same provider

Providers will submit claims using the following code and a primary ICD-10 code. Claims for children under age 21 provided prior to diagnosis will use Diagnosis code F99

90832	Psychotherapy, 30 min
90834	Psychotherapy, 45 min
90837	Psychotherapy, 60 min
90839	Psychotherapy for crisis, first 60 min
90849	Psychotherapy for crisis each additional 30 minutes

Family Therapy

Family can be provided and is reimbursable to adults or children with a mental health condition. Children under the age of 21 are entitled to five sessions of individual therapy prior to being diagnosed with a mental health condition

Family therapy services is also reimbursable when provided to children under the age of 21 who has a history of one of the following risk factors:

- Separation from a parent/guardian due to incarceration or immigration
- Death of a parent/guardian
- Foster home placement
- CCS-eligible condition
- Food insecurity, housing instability
- Exposure to DV or other traumatic events
- Maltreatment
- Severe & persistent bullying
- Experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability.

OR

Child has a parent/guardian with at least one of the following risk factors

- Serious illness or disability
- History of incarceration
- Mental Health Disorder
- Substance Abuse Disorder
- History of DV or interpersonal violence
- Teen parent

Family therapy is also reimbursable on an inpatient basis if the member is an infant (under 1 year of age) who are hospitalized in a neonatal intensive care unit.

Family Therapy is limited to a maximum of 50 minutes when the identified client is not present (CPT code 90846) or a maximum of 110 minutes when the client is present (CPT code 90847 plus CPT code 99354)

CPT codes 90846, 90847 and 90853 may not be billed on the same day for the same beneficiary

Family Therapy must be composed of at least two family members. Providers must bill for family therapy using the CenCal ID of only one family member per therapy session for CPT codes 90846, 90847 and 99354. For multiple-family group therapy, providers must use the CenCal ID of only one family member per family

Providers will submit claims using the following CPT codes and an ICD-10 code of the identified client under whose CenCal ID billing is being submitted. Claims for children under age 21 provided prior to diagnosis will use Diagnosis code F99. Claims for children who are at risk of developing a mental health condition, will use Diagnosis code Z 65.9

Claims when the CenCal member is an infant and admitted to a NICU will use diagnosis code P96.9

Providers will submit claims using the following CPT codes

CPT Code	Description
90846	Family Psychotherapy (without client present) 50 min
90847	Family Psychotherapy, (with client present) 50 min
90849	Multiple-family group therapy
99354	Prolonged services in the outpatient setting requiring direct patient contact beyond the time of the usual service, first hour

Group Therapy

Group Therapy is defined as consisting of at least two but not more than eight persons at any session. There is not restriction as to the number of CenCal members who must be included in the group's composition. Group Therapy are expected to be in duration at least one and one-half hours.

Providers will submit claims using CPT code 99368 and ICD 10 diagnosis code.

Case conferences

Case conference attendance are limited to conferences lasting 30 min or more with professionals immediately involved in the case or recovery of the client.

Providers will submit claims using CPT code 99366 (member or family present) or CPT 96368 (member or family not present)

Psychological and Neuropsychological testing

Psychological and Neuropsychological testing requires a pre-services authorization. Providers after receiving an approved RAF must submit a TAR 50-1 & addendum to CenCal for pre-service authorization.

Claims for the following CPT codes must include an itemization of the tests performed. Providers must list the test performed on an attachment.

96105, 96110, 96112, 96113, 96121, 96130 -96133, 96136 – 96139, 96146

Claims billed with CPT codes 96105, 96116 and 9612 must include an attachment specifying the amount of time spend completing each of the following:

- Administration of test(s)
- Interpretation of test results
- Preparation of the report

The appropriate test scoring or written test report procedure code must be billed on the same claim as the test administration.

For a listing of frequency limits for Psychological & neuropsychological testing as well as medical necessity criteria, these can be found on our website.

Medication Management services

Medication management providers will utilize relevant Evaluation & Management (E/M) codes for services provided to new and existing clients according to level of care criteria.

Medication management providers are expected to familiarize themselves with the guidelines pertaining to E/M codes that can be found in the Medi-Cal provider manual.

Psychotherapy add-on codes to E/M services: (CPT 833, 936, 938). Providers must clearly document in the member's medical record the time spend providing psychotherapy services. In other words, time spend on the E/M service and the psychotherapy service may not be bundled but must be indicated separately.

Psychotherapy add-on codes can be used for discussions with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of treatment options
- Instructions for treatment and/or follow-up
- Importance of compliance with treatment options
- Risk factor reduction
- Patient and family educations

Providers are advised that psychotherapy services must be individualized and not comprise of "cut and paste" interventions that are the same across different patients or different sessions for the same patient.

E8: Substance Use Services

Services to address substance use disorders are a covered benefit for CenCal Health members. Primary Healthcare Providers are expected to screen members for risky or hazardous substance use and to administer additional screenings as appropriate. Members who are identified with risky or hazardous substance behaviors can be provided with behavioral counseling interventions (Substance, Brief Intervention and Referral to Treatment or SBIRT) either at the PCP location or referred to a provider in the community. Members are entitled to at least one but up to three behavioral counseling intervention sessions per year. Additional sessions are allowed as long as the member meets medical necessity. SBIRT services can be provided in three separate sessions or can be combined into one or two visits and it can be provided in-person, by telephone, or by telehealth modality.

Members who meet criteria for a substance use disorder as defined by the DSM V must be referred to County Department for Substance Treatment Services (see

Section **F3: County Substance Use Services** of the Manual for more information). Primary Healthcare Providers will continue to provide basic case management services while a member is receiving substance use treatment services and coordinate the member's medical care with the treating substance use provider.

CenCal primary care providers may provide professional withdrawal or treatment services within their scope of practice, including prescribing medications to reduce symptoms of withdrawal or providing Medication Assisted Treatment (MAT) medications, i.e. Suboxone.

Referral process County Alcohol and Drug Services

San Luis Obispo County Alcohol & Drug Services:

- CenCal Health Primary Care Providers and Mental Health providers who determine a member would benefit from Substance Use Treatment Services can contact the Behavioral Health Department to coordinate care at (805) 562-1600 or by submitting a RAF through the Provider Portal.
- Members can self- refer or can be referred by a CenCal Health provider by calling County ACCESS Line at (800) 838-1381 OR Faxing a referral to (805) 781-1171 and including member identification information and current contact information, name and contact information of referring provider, signed authorization to release information and results of the last physical examination that completed within the previous 12 months.

Santa Barbara County Alcohol & Drug Services:

- CenCal Health Primary Care Providers and Mental Health providers who determine a member would benefit from Substance Use Treatment Services can contact the Behavioral Health Department to coordinate care at (805) 562-1600 or by submitting a RAF through the Provider Portal.
- Members can self-refer or can be referred by a CenCal provider by calling County ACCESS line at (888) 868-1649 or faxing a referral to (805) 681-5117 and including member identification information and current contact information, name and contact information of referring provider, signed authorization to release information and results of the last physical examination that completed within the previous 12 months.

For members with co-occurring mental health and substance use presentations see diagram below to assist with decision-making process.

	Risky Substance Use & Substance Use in Remission	Substance Use (DSM V)
No mental health symptoms	Behavioral Counseling services (SBIRT)	County Alcohol and Drug Services
Mental Health symptoms with mild to moderate impairments	SBIRT and referral to CenCal Behavioral Health Department	County Alcohol and Drug Services and CenCal covered mental health services

Mental Health symptoms with moderate to severe impairments	County Mental Health Services	County Mental Health Services
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E9: Non-Emergency Medical Transportation Services and Non-Medical Transportation

Non-Emergency Medical Transportation (NEMT) services are accessible for members whose medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and specialized transportation is required for the purpose of obtaining needed medical care.

NEMT requires prior authorization (TAR). CenCal Health reviews the 'Physician Certification' form for medical necessity. This form can be filled and signed by the member's physician, dentist, podiatrist, physical or occupational therapist or mental health or substance use disorder provider. Ventura Transit System (VTS) is CenCal Health's transportation vendor. To schedule transportation services, members or providers may contact VTS directly at (855) 659-4600. *Prior authorization is not required when it is medically necessary for a hospital discharge to a SNF, or for a transfer to another facility.*

The 'Physician Certification' form must include *at a minimum*, the following components:

- a) **Functional Limitations:** The physician is required to provide the member's specific physical and medical limitations that preclude their ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- b) **Dates of Service:** The physician is required to provide start and end dates for the prescribed NEMT service; authorizations may be for a maximum of 12 months.
- c) **Mode of Transportation:** The physician is required to list the mode of transportation that is to be used when receiving these services (ambulance, gurney/litter van, wheelchair van or air transport).
- d) **Certification Statement:** The physician is required to certify that medical necessity criteria were met to determine the prescribed mode of transportation.

To view or print the 'Physician Certification' form, please go to www.cencalhealth.org.

Completed and signed Physician Certification forms should be submitted to CenCal Health, Utilization Management (UM) Department via fax or uploaded securely through the File Drop Link:

- CenCal Health UM Fax: 805-681-3071
- CenCal Health's Secure File Drop Link : <https://transfer.cencalhealth.org/filedrop/hs>

The following four modalities of NEMT transportation are available, in accordance with the Medi-Cal Provider Manual and the California Code of Regulations (CCR):

1. **Ambulance:**
 - a. Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
 - b. Transfers from an acute care facility to another acute care facility.
 - c. 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).
 - d. Transport for members with chronic conditions who require oxygen if monitoring is required.

2. **Gurney/Litter Van:** For members whose medical and physical condition does not meet the need for NEMT via Ambulance but meets both the following:
 - a. 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
 - b. Requires specialized safety equipment over and above what is normally available in passenger cars, taxicabs or other forms of public conveyance

3. **Wheelchair Van:** For members whose medical and physical condition does not meet the need for NEMT via Gurney/Litter Van but meets any of the following:
 - a. 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
 - b. Requires that the member be transported in a wheelchair, receive assistance to and from the residence, vehicle and/or place of treatment because of a disabling physical or mental limitation
 - c. Requires specialized safety equipment that is considered over and above what is normally available in private vehicles, taxicabs or other forms of public conveyance

4. **Air:** NEMT via air is necessary only when practical considerations render ground transportation as not feasible due to the member's medical condition. The medical necessity for NEMT via Air must be included in the Physician Certification form.

Non-Medical Transportation (NMT)

Effective October 1, 2017, Non-Medical Transportation Services are covered and provided through CenCal Health for all Medi-Cal services, including those not covered by CenCal Health's contract. Services that are not covered under the CenCal Health contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations..

The following NMT services are covered:

Round trip transportation for a member by passenger car, taxicab, bus or other form of public or private conveyance (private vehicle), as well as mileage reimbursement for medical, mental health or substance use treatment purposes when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets. Before getting approval for mileage reimbursement, a member must state to CenCal Health by phone, by email or in person that they tried to obtain all other reasonable transportation choices and could not obtain one. The NMT request must be the least costly method of transportation that meets the member's needs.

- Round trip NMT is available for the following:
 - Medically necessary covered services.
 - Members picking up drug prescriptions at their local pharmacy
 - Members picking up medical supplies, prosthetics, orthotics and other equipment.
 - Members requiring transportation from an out-of-county psychiatric hospital to their home or a crisis residential treatment facility
- NMT must be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- CenCal Health may use prior authorization processes for approving NMT services.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, CenCal may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. CenCal must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service and is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- CenCal Health does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to CenCal in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
 - Has no valid driver's license.
 - Has no working vehicle available in the household.
 - Is unable to travel or wait for medical or dental services alone.
 - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Authorization

- VTS determines the transportation benefit to be provided to the member based on the outcome of a series of questions completed during the intake screening from a triage screening form provided by CenCal Health.
- If determined, NMT request is for a local CenCal Health/Medi-cal contracted provider, no authorization is required and VTS will coordinate the transport.
- If the NMT request is for an out of area trip, CenCal Health requires an authorization to be obtained from CenCal Health's Member Services Department. Once authorization is in place, VTS will then coordinate the out-of-area transport.
- NMT services do NOT require a Physician Certification Statement (PCS) Form.

NMT does not apply if:

- An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service.

You need assistance from the driver to and from the residence, vehicle or place of treatment due to physical or medical condition.

Members and/or Providers may contact Ventura Transit System (VTS) directly at (855) 659-4600 for transportation services or CenCal Health's Member Services Department at (877) 814-1861 for assistance.

To view or print the [Non-Emergency Medical & Non-Medical Transportation Services Reference Guide](#), please go to www.cencalhealth.org.

E10: Importance of Fluoride Varnish

Topical application of fluoride varnish is a covered benefit for pediatric CenCal Health members.

Tooth decay is one of the most common chronic diseases of childhood. The early application of fluoride varnish protects the primary teeth, and should be performed after the first teeth erupt until age five.

Topical fluoride varnish is more effective in preventing tooth decay than other forms of topical fluoride and is more practical. It is safe for babies and young children and can be swabbed directly onto the teeth in less than three minutes, and sets within one minute of contact with saliva. The application requires no special dental equipment and can be applied with minimal training.

Because many dentists are not willing to see young children, primary care providers have an opportunity to help prevent tooth decay by applying fluoride varnish in the primary care setting.

Billing for Fluoride Varnish

- Use CPT code 99188 - topical application of fluoride.
- Reimbursement includes all materials and supplies needed for the application.

- Once teeth are present, treatment is covered up to 3 times in a 12-month period.

For staff trainings or other questions please contact our Population Health Team at populationhealth@cencalhealth.org.

E11: Postpartum Care

CenCal Health has carved out postpartum visits from the global reimbursement for obstetric care so that providers can bill for these visits separately fee-for-service. This is an added financial incentive to complete timely postpartum care within one to twelve weeks after birth, followed by ongoing care as needed. OB providers do not receive a denial when billing globally without the inclusion of this service, so it is important to bill for postpartum visits separately. Providers can bill CenCal Health for this service using CPT code Z1038.

E12: Steps to Take for Tobacco Cessation

Documenting patient tobacco use (including cigarettes, cigars, chew, vapes, e-cigarettes, etc.) and providing brief clinical interventions is important to quality patient care. Clinician-delivered brief interventions enhance motivation and increase the likelihood of successful and multiple quit attempts.

The steps below outline CenCal Health's preferred methods for tobacco cessation.

1. Ask all adolescent, adult, and pregnant patients if they are a current smoker or exposed to tobacco smoke. **Specifically ask about use of vapes/e-cigarettes.**
2. Document patient tobacco use using one of the following identification methods:
 - Add tobacco use as a vital sign in the chart or EMR
 - Use [ICD-10 codes](#) in the medical record
 - [Codes for tobacco use](#)
 - [Codes for vape/e-cigarette use](#)
 - Place a chart stamp in the medical chart
 - Record tobacco use on a completed Staying Health Assessment (SHA)
3. If identified as a smoker, discuss smoking cessation regimens (quitting options) with the patient.
4. Once you establish the appropriate cessation regimen for the patient, prescribe the appropriate cessation agent.
 - Please see <https://medi-calrx.dhcs.ca.gov/> for the current formulary.
 - If applicable, instruct patient to take their prescription to the pharmacy for fulfillment.
5. Refer patient to **individual, group, and telephone** counseling. Counseling is strongly recommended for cessation success.

Please note: all pregnant patients who smoke should be offered at least one face-to-face tobacco cessation counseling session per quit attempt.

- **Individual counseling**

This can be performed at your office visit, and can include one of the following validated counseling methods:

- [5 As \(Ask, Advise, Assess, Assist, Arrange\)](#)
- [5 Rs \(Relevance, Risks, Rewards, Roadblocks, Repetition\)](#)
- Other method of your choice

Use the following CPT codes for reimbursement for individual counseling:

- **99406:** symptomatic; smoking and tobacco use cessation counseling visit, greater than 3 minutes, up to 10 minutes
- **99407:** symptomatic; smoking and tobacco use cessation counseling visit; greater than 10 minutes

- **Group counseling**

Refer patient to a group cessation class. Contact the local Public Health Department for information on local classes and support services:

- **Santa Barbara County:** (805) 681-5407
- **San Luis Obispo County:** (805) 781-5564

- **Telephone counseling**

Refer patient to the CA Smokers' Helpline at (800) NO-BUTTS or (844) 8-NO-VAPE

- Give patient [a flyer](#) with contact information for the CA Smokers' Helpline
- Or log onto to Helpline's [web referral](#) to refer patient directly. Helpline counselors will then contact patient's personal phone

Refer **all** pregnant patients who smoke to the CA Smokers' Helpline

Notes:

- CenCal Health members who have questions about this benefit or need assistance can call **Member Services** at (877) 814-1861

URLs for above hyperlinks:

International Classification of Diseases (ICD)-10 Codes

<https://ctri.wisc.edu/wp-content/uploads/sites/240/2017/09/icd10.pdf>

Five Major Steps to Intervention (The "5A's")

<https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.pdf>

Patients Not Ready To Make A Quit Attempt Now (The "5 R's")

<https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5rs.pdf>

NO BUTTS Free Quit Smoking Program

<https://www.nobutts-catalog.org/collections/community-partners/products/flyer-helpline-services>

NO BUTTS Helpline Referral Options

<https://www.nobutts.org/helpline-referral-options>

E13: Whole Child Model (WCM) and California Children's Services (CCS)

As of July 1, 2018, CenCal Health began administering The Whole Child Model (WCM) for the California Children's Services (CCS) Program for all eligible members. The WCM is a delivery system that will provide comprehensive, coordinated services for children and youth with special healthcare needs through patient and family centered approach, ensuring all necessary care for the whole child. 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 and Santa Barbara counties with eligible CCS conditions and who meet CCS income guidelines. For CCS clients, who have other health coverage (OHC) and CCS eligibility, the County CCS still assumes case management and financial responsibility.

CCS Eligibility

The CCS program delivers specialized services to financially and medically eligible children under the age of twenty-one (21) who have CCS eligible conditions, as defined in Title 22, California Code of Regulations. The CCS program provides medical case management and care coordination to eligible children. Services offered include diagnostic exams, medical treatment, transportation assistance, and physical and occupational therapies.

If a provider suspects that a child has a CCS eligible condition, he/she should contact the member's Primary Care Physician (PCP) and inform them of such suspicion. The member's PCP will then make a referral for CCS eligibility. Referrals could be made to the local County CCS office or CenCal Health. The County CCS office is responsible for CCS medical eligibility determination. CenCal Health is responsible for authorizations of CCS related services and care management of established CCS members. CCS members are assigned to a PCP who is CCS paneled and contracted with CenCal Health.

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. RAFs are required for CCS eligible members, excluding services that do not require a RAF. Hospital should take care in checking eligibility to take note of both the assigned PCP and potential CCS eligibility.

Claims Billing- Please refer to Section K, Claims, for further instructions.

Pharmacy Utilization - [Pharmacy](#)

URLs for above hyperlinks:

CenCal Health Pharmacy Services:

www.cencalhealth.org/providers/pharmacy/forms-downloads-fax/

CenCal Health Referral Authorization

www.cencalhealth.org/providers/authorizations/referrals/

E14: Community Based Adult Services (CBAS)

CBAS is a benefit available to eligible Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care. Eligibility to participate in CBAS is determined by CenCal Health.

CBAS centers offer therapeutic and social services in a community-based day healthcare program. Services are provided according to a six-month plan of care developed by the CBAS center’s multidisciplinary team and CenCal Health’s Health Services team. The services are designed to prevent early and unnecessary institutionalization and to keep recipients as independent as possible in the community.

CBAS services include:

- an individual assessment
- professional nursing services
- physical, occupational and speech therapies
- mental health services
- therapeutic activities
- social services
- personal care
- a meal
- nutritional counseling
- transportation to and from the participant's residence and the CBAS center

Billing Codes and Reimbursement Rates:

The billable reimbursement rate is determined by the date of service.

HCPCS Code	Description	Rate*
H2000	Comprehensive multidisciplinary evaluation	80.08
S5102	Day care services, adult; per diem	76.27
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter.	64.83

Authorization:

CBAS initial assessment and transition days do not require a TAR. CBAS regular days of attendance require a Treatment Authorization Request (TAR). Please refer to **Section H: Referrals and Authorizations** of the Provider Manual.

E15: Palliative Care

Description of Palliative Care Benefits

Palliative Care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The CenCal Health benefit includes access to a multidisciplinary care team that coordinates and supports the member’s advance care planning and their medical, mental, emotional, and spiritual needs. The benefit is delivered on a predominantly outpatient basis; however, the benefit is available to members at an inpatient facility.

Palliative Care does not require the Member to have a life expectancy of six months or less and may be provided concurrently with curative care. The provision of Palliative Care shall not result in the elimination or reduction of any Covered Services or benefits and shall not affect a beneficiary's eligibility to receive any services, including Home Health Services, for which the beneficiary may not have been eligible in the absence of receiving Palliative Care.

Member Eligibility Criteria for Palliative Care

The Palliative Care benefit shall only apply to CenCal Health Medi-Cal Members who are not Medicare/Medi-Cal (dual-eligible) Members. A Member who is receiving Palliative Care may choose to transition to Hospice Care if they meet the Hospice eligibility criteria; Members may not be concurrently enrolled in Hospice Care and Palliative Care.

Member eligibility for Palliative Care services includes the minimum criteria as set by the DHCS All Plan Letter (APL) 18-020, or successor policy. Effective January 1, 2019 this includes the DHCS criteria for pediatric Members (under age 21).

In addition to the State minimum criteria for adult Members (21 years and older), CenCal Health eligibility criteria for adult Palliative Care will also include the following:

- Members with Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Cancer, or Liver disease who may not meet the disease specifications set by DHCS but who are clinically deteriorating and whose death within a year would not be unexpected based on clinical status.
- Members who meet DHCS criteria but have who still have reservations about participating in Advance Care Planning or foregoing emergency room treatment.
- Members who have other advanced or progressive illnesses whose death within a year would not be unexpected based on clinical status. Included illnesses are advanced ALS, Multiple Sclerosis, Interstitial Lung disease, Primary Pulmonary Hypertension, HIV/AIDS, and end stage rheumatologic illnesses.
- Illnesses not indicated above may be considered on a case-by-case basis with approval from a CenCal Health Medical Director.

Medical records should be available for any Member upon request from CenCal Health to determine eligibility for the benefit.

Authorization Requirements for Palliative Care Program Benefit

A TAR is required for initial Palliative Care assessments and consultations. This may be submitted by a Member's PCP, specialist, or a contracted CenCal Health Palliative Care provider. It is recommended to submit supporting documentation particularly for Members under age 21. Members may contact CenCal Health directly to self-refer for services.

After completion of the initial assessment and consultation and the Member has agreed to participate in the Palliative Care Program, a TAR is required to commence

ongoing Palliative Care Program services. A TAR will be required for every subsequent six months (up to twelve [12] units, where each unit is a two-week global period) of Palliative Care Program services, re-certifying the Member's qualifying condition along with an updated Plan of Care and/or recent progress note.

Palliative Care organization providers must maintain appropriate medical records documenting all services rendered to Members, and submit Palliative Care utilization data and other records as required by CenCal Health to substantiate the services rendered.

Consideration of Prospective Providers for Palliative Care Agreement with CenCal Health

Provider organizations should meet the following criteria to be considered for a contract with CenCal Health for Palliative Care Program services:

- Organization and all providers and subcontractors are enrolled Medi-Cal providers
- Clinical staff are trained in Palliative Care from an appropriate credentialing or oversight organization
- Medical Director must have specialized and current Palliative Care training and/or certification as a Palliative Care physician
- 24/7 Telephonic Care with access to a nurse who has access to the Member's medical record and Plan of Care to assist with informed decision-making
- Ability to collect and submit all required clinical, encounter, and quality data as required by CenCal Health
- Core staffing identified in a roster to include, at-minimum, a medical director, registered nurse(s), social worker(s), administrator with:
 - Palliative Care training and/or certification obtained to-date, and/or any future training/certification planned.
 - Pediatric training and/or certification for Providers able to offer Palliative Care services to pediatric Members (under the age of 21) for staff who would render services to pediatric Members, appropriate to their scope of services.
- If your organization will contract for some of these services, please describe the contractual arrangements.
- If organization is not a Hospice and/or Home Health organization: submission of a letter or memorandum of understanding with local Hospice and/or Home Health organization(s) who can accept patients who need those services.

E16 Diabetes Prevention Program

Description of Diabetes Prevention Program

Diabetes Prevention Program ("DPP") is an evidence-based lifestyle change program, taught by peer coaches, designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. The Centers for Disease Control and Prevention ("CDC") established the National DPP and set national standards and guidelines, also known as the CDC Diabetes Prevention Recognition

Program ("DPRP"), for the effective delivery of the national DPP lifestyle change program.

Provider Requirements for DPP Agreement with CenCal Health

Provider organizations must be actively certified by the CDC as a recognized DPP program in connection with the DPRP program and Medi-Cal DPP standards. Providers who are in the process of obtaining CDC DPP certification may contact CenCal Health to initiate the contracting process.

Members must be screened per CDC guidelines to ensure they meet CDC DPRP participant eligibility for the benefit. Peer coaches rendering for the provider organization must be adequately trained to administer the DPP curriculum in accordance with the CDC DPRP program guidelines. Providers must maintain adequate documentation of all services, including program milestones (when met), and must furnish any documentation required by CenCal Health to substantiate the services billed.

Due to the serial nature of DPP coursework, Providers must offer a new series of DPP courses within their service area at least quarterly to ensure adequate access for Members to the benefit.

Authorization Requirements for DPP Program Benefit

A RAF from a Member's PCP is required by CenCal Health for payment of any DPP program services. Referral Providers and case managers can direct Members to contact their PCP for a referral to CenCal Health contracted DPP provider. A contract for DPP services is required to be eligible to receive a RAF for DPP services. Providers should refer to the Medi-Cal State Manual and State website for details on coding and billing for services.

E17: Blood Lead Level Screening in Children

In accordance with DHCS contractual obligations, all providers who see children up to 6 years of age must ensure that children are screened for blood lead levels (BLL) in accordance with the prevailing clinical guidelines. Providers are expected to screen children following the Bright Futures Periodicity Schedule as published by the American Academy of Pediatrics.

Providers must also:

- Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child at each periodic health assessment, information stating children can be harmed by exposure to lead. This education should begin at 6 months of age and continue until 72 months of age.
- Report BLL screening results to the California Department of Childhood Lead Poisoning Prevention.
- Document the reasons for not screening a child for BLL in the child's medical record.

Monitoring

Through the DHCS-required Facility Site Review process, CenCal Health verifies that applicable contracted providers reliably report BLL results to CLPPB, as required.

CenCal Health monitors the prevalence and timeliness of BLL testing in its membership, using the prevailing industry-standard methodology for BLL testing performance. BLL screening utilization is reviewed on a monthly basis to ensure that appropriate screening guidelines are being followed.

Providers will be notified on a monthly basis of all assigned members due for BLL screening. CenCal Health will provide targeted training to providers found to be underperforming of BLL screening.

Billing

Providers can bill CenCal Health for BLL testing using the following CPT procedure code:

- 83645 – Test for Blood Lead

Section F: Services Covered by Other Agencies

F1: Dental Services for Medi-Cal Members

Medi-Cal covers some dental services, including:

- Diagnostic and preventative dental hygiene (such as examinations, X-rays and teeth cleanings)
- Emergency services for pain control
- Tooth extractions
- Fillings
- Root canal treatments (anterior/posterior)
- Crowns (prefabricated/laboratory)
- Scaling and root planning
- Periodontal maintenance
- Complete and partial dentures
- Orthodontics for children who qualify

If members have any questions, want to learn more about dental services or want to find a dentist in your area, call Denti-Cal at 1-800-322-6384 (TTY 1-800-735-2922). You may also visit the Denti-Cal website at <https://www.dental.dhcs.ca.gov> or <https://smilecalifornia.org/>.

F2: Specialty Mental Health Services

County mental health plans (MHP's) are responsible for authorization and payment of a full continuum of specialty mental health services for CenCal members.

Medically necessary specialty mental health services include the following:

- Individual, family and group psychotherapy and rehabilitation services
- Medication support services
- Crisis intervention, stabilization and residential services

- Targeted case management services
- Therapeutic Behavioral Services, Intensive Home Based Services, Intensive Care Coordination and Therapeutic Foster Care for members under the age of 21.
- Psychiatric consultation in the Emergency Department
- Residential treatment, Partial Hospital Treatment or Intensive Outpatient services for a mental health, substance use or eating disorder.
- Electroconvulsive Therapy (ECT)

To qualify for specialty mental health services, adult members (over the age of 21) must meet the standard statewide specialty mental health medical necessity criteria, including having a covered diagnosis, demonstrating a significant impairment in at least one major area of functioning and meeting certain intervention criteria.

CenCal Health children and youth under the age of 21 qualify for specialty mental health services under EPSDT with the MHP when meeting the following criteria: the child or youth must have a covered diagnosis that would not be responsive to physical healthcare based treatment and the services are necessary to correct or ameliorate the identified mental illness or condition.

F3: County Substance Use Services

Under the Drug Medi-Cal Organized Delivery System (DMC-ODS), County Alcohol and Drug Services are providing a continuum of care for the treatment of substance use disorders modeled after the American Society of Addiction Medicine (ASAM) criteria. Covered services include:

- Withdrawal Management
- Intensive Outpatient & Outpatient services
- Opioid (Narcotic) Treatment Programs
- Recovery Services
- Case Management
- Perinatal & Non Perinatal Residential Substance Abuse services
- Out-patient therapy or medication services for a primary substance-use diagnosis.
- Residential treatment/Partial Hospital Treatment or Intensive Outpatient services for dual diagnosis, substance use disorders, or alcohol use disorders.

Members must meet medical necessity criteria in order to qualify for substance abuse services. Medical necessity criteria for adults is determined on the individual being diagnosed with a DSM V substance-related and addictive disorders with the exception of tobacco-related disorders and non-substance-related disorders and the individual meeting ASAM criteria for the specific service requested.

URLs for above hyperlinks:

Santa Barbara County

<http://countyofsb.org/behavioral-wellness/alcohol-home.sbc>

San Luis Obispo County

<https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Drug-Alcohol-Services.aspx>

F4: Tri Counties Regional Center

Tri-Counties Regional Center (TCRC) is one of twenty-one non-profit regional centers in California providing lifelong services and supports for people with developmental disabilities residing in San Luis Obispo, Santa Barbara and Ventura Counties.

TCRC operates two separate programs, each with different eligibility rules.

1. The Early Start program is for infants birth to 36 months, who are at risk of developmental disabilities or who have a developmental disability. An infant or toddler (birth to 36 months) is eligible for Early Start if they have a developmental delay of 33% in one or more of the following areas of development: Social, Adaptive, Physical, Communication, and Cognitive. In addition, children with multiple medical factors that place them at risk for a developmental delay such as low birth weight, prematurity (less than 32 weeks), prenatal exposure to drugs, alcohol or teratogens, or if born with a condition with a known probability of causing a disability or delay such as Down Syndrome or other genetic conditions. Eligible children and their families may receive a variety of early intervention services including, but not limited to:
 - Infant stimulation (specialized instruction) in your home or community
 - Family resource Centers for parent-to-parent support.

2. The Regional Center general services program is for individuals older than 36 months who have a diagnosis of Autism, Epilepsy, Intellectual Disability, Cerebral Palsy, or a condition similar to Intellectual Disability that require treatment similar to a person with Intellectual Disability. In addition, their condition needs to be substantially handicapping and have begun before their 18th birthday. Once eligibility is established, services are available to the member for the duration of their life. Services may include but are not limited to:
 - Respite services
 - Independent Living Supports
 - Supported living services
 - Community Care facilities
 - Employment support
 - Safety supports i.e. tracking devices, crisis support services

To apply for services, members or providers can contact the regional center and request an eligibility evaluation. The Regional Center evaluation process may take up to 90 days.

For more information regarding TCRC, please contact the specific county in which a CenCal Health member currently resides or please visit the [Tri-Counties Regional Center](#) website.

Santa Barbara County Offices:

Santa Barbara: (805) 962-7881 or (800) 322-6994

FAX: (805) 884-7229

Santa Maria: (805) 922-4640 or (800) 266-9071

FAX: (805) 922-4350

San Luis Obispo County Offices:

San Luis Obispo: (805) 543-2833 or (800) 456-4153

FAX: (805) 543-8725

Atascadero: (805) 461-7402

FAX: (805) 461-9479

F5: Local Education Agency

A Local Education Agency (LEA) provides certain Medically Necessary preventive, diagnostic, therapeutic, and rehabilitative services to eligible Members age three (3) years and older who are identified as Children with Special Health Care Needs (CSHCN) while in school.

A Member may receive LEA services from their LEA in accordance with the Member's Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP).

LEA Services

LEA educational support services may include, but are not limited to, the following, when identified on the Member's IEP or IFSP.

- Health and mental health evaluation;
- Health and nutritional assessment and education;
- Developmental assessment;
- Vision assessment;
- Hearing assessment;
- Education and psychosocial assessment;
- Psychological and counseling services;
- Nursing services;
- School aid health services;
- Specialized medical transportation services and the associated mileage; and
- Therapy Services (OT, ST, ABA, Behavioral Therapy, Mental Health)

Identification and Referral of Members

- CenCal Health, LEA Practitioner or the Member's Primary Care Practitioner shall identify a Member eligible for LEA Services, as specified in Section III.B.I of this policy.
- Upon appropriate identification of a Member eligible for LEA services, CenCal Health, or the Member's PCP shall refer the Member to their LEA.
- A Member's PCP shall collaborate with CenCal Health and the LEA to coordinate the provision of Medically Necessary services identified on the Member's IEP or IFSP.

- The LEA must provide education to community providers and families on IEPs, as well as when LEA services, as opposed to health plan services, should be requested.

Provision and Responsibility

- CenCal Health is not responsible for the provision, or payment, of LEA services, except as specified in Section III.A.1-2 of this Policy. CenCal Health shall provide Medically Necessary Covered Services that are not available under the LEA.
 1. Services available through an LEA are not Covered Services under CenCal Health's contract with the Department of Health Care Services. Therefore, if a Member's parents exercise their right to opt out of LEA services, such services will not be covered and paid for by CenCal Health in lieu of otherwise available LEA services, which are paid by the State.
 2. Whenever the LEA services overlap with Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT), CenCal Health and its Network:
 - Assess what level EPSDT Medically Necessary services the Member requires.
 - Determine what level of service (if any) is being provided by the LEA.
 - Coordinate the provisions with other entities, such as CenCal Health, to ensure such entities are not providing duplicative services, and that the child is receiving all Medically Necessary EPSDT services in a timely manner.
- CenCal Health has the primary responsibility to provide all Medically Necessary EPSDT services, including services which exceed the amount provided by the LEA.
- An LEA will never be considered the primary provider of Medically Necessary EPSDT services, as this is the responsibility of CenCal Health.

Section G: Eligibility Verification and Enrollment

G1: Eligibility Frequently Asked Questions (FAQ)

CenCal Health currently serves approximately 203,000 residents in our service area of Santa Barbara and San Luis Obispo counties.

Does CenCal Health Determine Member Eligibility for its Medi-Cal (SBHI & SLOHI) Members?

No, the Department of Social Services (DSS) and/or each counties Social Security Administration determine SBHI and SLOHI eligibility.

CenCal Health's Member Services Department provides:

- Understanding how the Health Plan works
- Selecting a Primary Care Provider (PCP)
- Finding a specialist
- Benefit education
- Filing a complaint or appeal
- Arranging interpreter services

- Scheduling appointments
- Replacing Health Plan identification cards
- Transportation needs for those members that qualify

REMINDER: Always verify a member's eligibility status prior to treatment!

All providers are urged to verify member eligibility and PCP assignment (or Special Class status) prior to rendering services. This will serve to:

- Reinforce case management
- Avoid possible referral/authorization/claims problems
- Identify instances of member misrepresentation

Who are Medi-Cal (SBHI & SLOHI) Special Class Members?

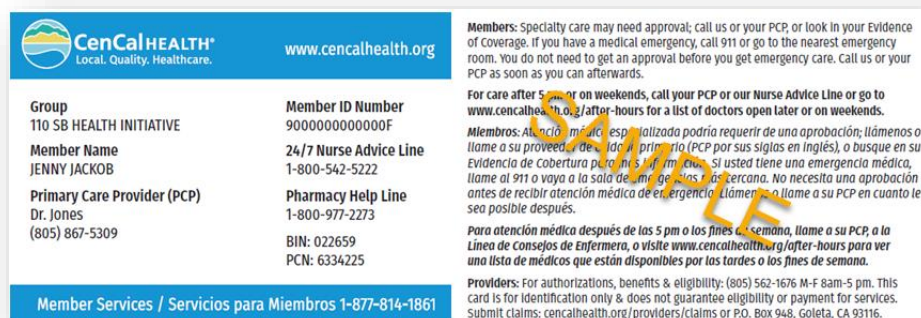
Any SBHI/SLOHI contracted provider who is willing, can see members who are Special Class. Special Class Members are considered fee-for-service and are assigned to CenCal Health; therefore, they do not require Referral Authorization Forms (RAFs), though they may require a Prior Authorization Request when appropriate.

Categories for Special Class include:

- The first month of eligibility
- Members that reside in long-term care facilities (skilled nursing or institutions for the developmentally disabled)
- Members who have met their share-of-cost
- Members in hospice
- Members that reside out of county
- Members that are qualified under the Genetically Handicapped Persons Program

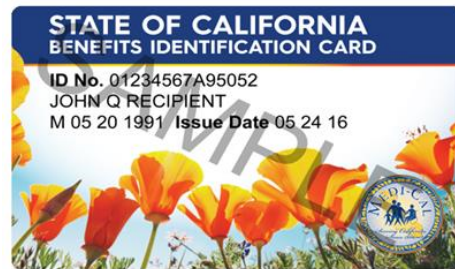
Are CenCal Health members issued ID cards?

Yes, CenCal Health members receive an Identification Card, as shown below. The group lists the program under which the member is covered. Other information printed on the card includes member name, ID number, PCP name and PCP phone number. These cards are issued only once, and are reissued only when information on the card changes. These cards are intended only to be a means of identification. They are not considered proof of eligibility.



The State also issues a permanent, plastic ID card for all Medi-Cal members called the "Benefits Identification Card" or BIC. Currently there are two versions of the BIC that members may present (see examples below).

The BIC is a permanent card, which does not provide proof of eligibility. Providers must verify eligibility information using the information on this card through one of the various options made available.



How do I verify member eligibility?

Providers can access CenCal Health eligibility information using two options.

Option 1: Via CenCal Health Website: www.cencalhealth.org

You can verify eligibility for CenCal Health members as well as State Medi-Cal members through our website. First, the provider must have an active web account. To create a web account, contact providerservices@cencalhealth.org. Once you are logged into the restricted 'For Providers' section, click the Eligibility tab on the left hand side, enter the CenCal Health Member ID and date of service. If the member is not eligible through CenCal Health, you have the option to check with DHCS for further eligibility information.

Option 2: Via CenCal Health's Member Services Department: Toll Free Number (877) 814-1861, select option 3. A representative of the Member Services Department can provide information for CenCal Health eligible members. Be prepared to give your provider's identification number (NPI).

Medi-Cal Eligibility Verification options available through the State

Note: Options for eligibility verification currently made available by the State do not take into account the need for SBHI and SLOHI providers to verify a member's PCP. PCP affiliation is important, as Referral Authorization Forms (RAFs) from the PCP are needed for most specialty services.

Automated Eligibility Verification Service (AEVS)

AEVS (800) 456-2387 is a free telephone service provided by the State for Medi-Cal providers. AEVS requires the use of your Provider Identification Number (PIN).

What are Aid Codes?

An aid code is the two digit alphanumeric number, which is used to assist in identifying the types of services for which Medi-Cal recipients are eligible.

What if I see a Medi-Cal member that is not SBHI or SLOHI?

CenCal Health is a State contracted Medi-Cal Managed Care plan which delivers care in San Luis Obispo and Santa Barbara counties. If a member resides in a different county, they may be eligible with another County Managed Care plan. Please check with the Managed Care plan in the county the member resides for

eligibility and guidelines. If the member is eligible with State Medi-Cal, you can bill Affiliated Computer Systems (ACS) following State Medi-Cal guidelines.

Is a CenCal Health member eligible to see a doctor out of county?

If a member is outside of the health plan's service area (Santa Barbara and San Luis Obispo Counties) and needs medical services, they are instructed to call their PCP unless it is an emergency or urgent situation. If it is an emergency or urgent situation, they may go to the nearest urgent care facility, emergency room or call 911. For non-urgent issues, a member's PCP must authorize (with a RAF) any medical care. It is the Provider's responsibility to check eligibility and obtain a RAF from the assigned PCP. Providers must be Medi-Cal* certified in order to be reimbursed.

**Out of State providers need to be Medicaid certified.*

G2: Share of Cost (SOC) Frequently Asked Questions (FAQ)

What is Share of Cost?

Share of Cost (SOC) is a monthly dollar amount, which a patient is required to pay before he/she becomes eligible with Medi-Cal. The SOC amount is based on the income information supplied by the patient to his/her Eligibility Worker at the Department of Social Services.

CenCal Health is not involved with determining SOC or eligibility.

(Note: If the member does not have any medical expenses for a particular month, no SOC is paid)

Is a Share of Cost (SOC) a Co-Pay?

No, a Medi-Cal recipient's SOC is similar to a private insurance plan's out-of-pocket deductible. This SOC is monthly and is based on the amount of income a recipient receives in excess of "maintenance need" levels (determined by the State). Medi-Cal rules require that recipients pay income in excess of their "maintenance need" level toward their own medical bills before Medi-Cal begins to pay.

To whom does the member pay a SOC payment?

A patient can pay or make a payment plan for his/her SOC with any Medi-Cal provider. The provider can go into the CenCal Health website and clear the member's SOC.

SOC can also be met with providers who are not Medi-Cal certified. In this case, the member must get a receipt with the following information: provider name pre-printed company letterhead, procedure code, date of service, and total amount paid. The patient must take this to his/her Eligibility Worker to have the paid amount applied towards their SOC. Additionally, the patient can pay providers who are not medical providers (such as dentists), or pay for services which are not normally Medi-Cal benefits such as non-formulary medications and circumcisions.

What does "payment plan" mean?

If a patient cannot pay the total SOC amount or has a large SOC and needs to make payments, the patient can make a payment plan with the provider; this is sometimes call obligating the SOC. The payment arrangements will be entirely

between the patient and the provider. CenCal Health does suggest that this agreement be in writing.

Important: When arrangements are made to accept payments for SOC amount owed, the entire SOC amount owed should be cleared immediately. Providers should never wait to clear the SOC until the entire amount is paid. This may keep the patient from obtaining other medical services if needed.

SOC patients are considered 'cash pay' patients until their SOC is met for a particular month. If the member does not fulfill an obligation, your office policy for "nonpayment" can apply. CenCal Health is not responsible and cannot be billed.

When does a SOC patient become Medi-Cal eligible?

When the patient meets their monthly SOC and the provider clears the SOC amount as described below.

What does "meeting share of cost" mean?

This means a patient's total SOC amount is paid.

What does "spending down SOC" mean?

This means the provider has applied or cleared SOC with the State.

How do I apply or clear SOC?

Providers collect payments from the patient or accept the patient's payment plan to pay for services that are rendered up to this SOC amount. Providers should immediately submit a SOC clearance transaction to the State using either of the methods below.

CenCal Health Website Clearance: www.cencalhealth.org

From the restricted section, select 'Transaction Services' then select 'SOC Clearance' and enter the information requested. This information is sent to DHCS to apply the payment information.

Note: You must have a password to get into this area. You can e-mail the Provider Services Department at providerservices@cencalhealth.org for a password so you can gain access to this secure area. Be sure to include the contact person's name and phone number, and the provider NPI number. Be prepared to give the provider's Tax Identification Number when you are contacted.

(Remember, the State, not CenCal Health clears the SOC. Although CenCal Health has the ability to transmit this information to the State, records are not kept in our database. We strongly suggest that you print out the information and place in the member's file.)

State Medi-Cal Website Clearance: <http://www.medi-cal.ca.gov/mcwebpub/login.aspx>

Must have a Medi-Cal provider number, PIN number and have a [Medi-Cal Point of Service \(POS\) Network/Internet Agreement](#) form on file. For information on Provider Enrollment, visit the Provider Enrollment page https://files.medi-cal.ca.gov/pubsdoco/prov_enroll.aspx

Please call the Telephone Service Center (TSC) at (800) 541-5555 for more information. A provider's failure to clear the patient's SOC immediately may prevent the patient from receiving necessary services or medicine, despite having fulfilled the SOC obligation.

Why does a patient's SOC amount change?

Depending upon fluctuations in the patient's monthly income, SOC amounts may change from month to month. Additionally, if a patient's SOC is partially met by multiple providers, different 'remaining' SOC amounts will appear during eligibility verification, until the total SOC is satisfied for that month. CenCal Health strongly suggests verifying eligibility at every visit to get updated SOC information.

Do SOC recipients have PCPs?

No the recipient will not have a PCP. Once a patient meets the total SOC obligation, they will become an SBHI/SLOHI member and will be classified as "Special Class" (not case managed). The member's PCP will appear as "CenCal Health" when verifying eligibility.

What is an LTC SOC?

This type of SOC is associated with a Long Term Care (LTC) Facility. This SOC is paid to the nursing facility by the patient before the LTC can send a claim to Medi-Cal for the remaining difference. This SOC is always handled by the LTC on their monthly billing; other medical providers are not affected. If you are not an LTC provider, do not charge a SOC to the patient who resides in a LTC.

Do I need to submit a TAR for approval if the patient has a SOC?

If the total SOC amount will not cover the full-billed charges and the SBHI/SLOHI allowable payment for the provider would be higher than the SOC amount, providers should follow the usual procedures for TAR approval. This authorization and a cleared SOC will allow you to bill CenCal Health the difference.

Example: Member has a SOC of \$50.00. The billed charges for the TAR required procedure are \$250.00. SBHI/SLOHI allowable is \$150.00. You will need to submit a TAR for authorization, spend down the SOC and after TAR is approved, and member is eligible with SBHI/SLOHI, bill SBHI for the remaining balance owed. SBHI/SLOHI pays up to the allowable, minus the SOC payment.

Do I submit a claim for a SOC patient?

If the patient's SOC equals or exceeds your total charges, do not submit a claim to CenCal Health. The paid/obligated SOC is considered the full payment and CenCal Health will not pay more than that amount.

Only when the SOC payment you receive is less than the SBHI/SLOHI/Medi-Cal allowable and the patient's SOC has been met, making them eligible, then there will be additional payment consideration. If you do submit a claim, you will need to enter the SOC information (see "Where do I put the SOC information" below).

Where do I put the SOC information on the claim?

Medical & Allied Health Providers

On the CMS 1500, claim forms enter the “claim codes” in box 10D and amount paid in Box 29.

For providers who bill on UB-04 Claim Forms

On the UB-04, claim forms enter the amount paid in Box 39-41 (value codes amount).

Section H: Referrals and Authorizations

H1: Medically Necessary (or Medical Necessity) Services

Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury; which means those services/products/therapies that are a covered benefit of CenCal Health and determined to be:

- Appropriate and necessary to diagnose a condition or to treat the symptoms, diagnosis, illness or injury.
- In accordance with evidence-based, professional, and nationally recognized clinical criteria, approved by CenCal Health.
- Not primarily for the convenience of the member, or the member’s physician or other Provider.
- Clinically appropriate in terms of type, frequency, extent, site and duration.

References: Title 22 CCR, Section 51303(a), CenCal Contract 08-85212, Exhibit E, Attachment 1, and CenCal Policy- Separation of Medical and Financial Decision Making (MM-UM24)

H2: Sensitive Services

All members have the right to confidentiality when receiving sensitive services or family planning services. If the member is a minor under age eighteen, they do not need the consent of their parent or guardian to receive these services. Members may obtain these services with their PCP or directly with any qualified Medi-Cal provider within or outside of the health plan or provider network. Members do not need a referral from their PCP.

Sensitive services include:

- Pregnancy testing and counseling
- Birth control
- AIDS/HIV testing
- Sexually transmitted disease testing and treatment
- Abortion (ending pregnancy) services and counseling
- Drug and alcohol abuse services and counseling
- Outpatient mental health services and counseling
- Sexual assault services

Family planning services include:

- Birth control (most require a prescription), including:
 - Birth control pills
 - Condoms
 - Contraceptive implant

- Diaphragm or cervical cap
- Depo Provera shot
- Emergency birth control (also called the morning after pill)
- Female condom
- Intra-uterine device (IUD)
- Spermicides
- Sterilization (tubal ligation and vasectomy)
- Pregnancy testing
- Pregnancy counseling

PCPs, County clinics, family planning providers, gynecologists, obstetricians, or multi-specialty groups can provide sensitive services. Please refer to your Contracted Provider Listing for a listing of providers.

H3: Request for Authorization

Providers may submit prior authorization requests via the [Provider Portal](#).

Alternatively, providers may choose to fax a completed prior authorization form (RAF, 50-1, 20-1, 18-1) to the Utilization Management Department at (805) 681-3071.

Please refer to **Section H: Referrals and Authorizations** of the Manual to determine which form (RAF, 50-1, 20-1 or 18-1) to use when submitting your request. In general, the services listed below require prior authorization from CenCal Health before rendering services:

- Psychological & Neuropsychological Testing
- Behavioral Health Treatment services (BHT) including ABA services
- Scheduled (elective) surgery
- Non-emergent medical transportation (NEMT)
- Non-emergent inpatient admissions, including Acute Inpatient and Rehab, Skilled Nursing Facilities (SNF), Congregate Living Health Facility (CLHF), Subacute Care, Long-Term Acute Care (LTAC)
- Hearing aid(s)
- DME over \$100 or cumulative cost for repairs are over \$250
- Orthotics over \$250
 - Therapeutic diabetic shoes and inserts always require prior authorization
- Prosthetics over \$500
- Home Health services (nursing, OT, Speech and; PT)
- Outpatient Therapy (OT, Speech, PT after first 18 visits)
- Home Infusion therapy
- Genetic testing
- Services with unlisted/miscellaneous procedure codes
- Wound care and medical supplies
- Non-participating, non-contracted, and out-of-network providers, including tertiary care facilities
- BHT-ABA
- Psychological and Neuropsychological Testing

- **Radiology and Imaging Services**, such as CT, CTA, MRI, MRA, PET, PET/CT, Nuclear Med
 - Submit your request to Care to Care via:
 - Phone (888) 318-0276 (Call Center is open Mon-Fri, 5:00am – 5:00pm)
 - Fax (888) 717-9660
 - [Care to Care's Portal](https://cencal.careportal.com/) at <https://cencal.careportal.com/>

To determine if a proposed treatment, therapy, procedure, or service code requires a prior authorization, please use our [Procedure Code Look Up](#)

URLs for above hyperlinks:

HCPC/CPT Procedure Code – Prior Authorization Requirement Search Tool
<https://procedureauth.cencalhealth.org/>

H4: RAF Exceptions

Referral Authorization Form (RAF) is required for all case managed CenCal Health members; however, there are a number of exceptions to this rule.

Services that are exempt from the RAF requirement:

- Special Class Members
- Sensitive Services (Family planning, sexually transmitted diseases appointments, abortion and HIV testing)
- Emergency Service
- Mental Health psychotherapy
- Mental Health Medication Management Services

Please reference the [Authorization](#) section of our website under 'Is a RAF required?' for more information.

URLs for above hyperlinks:

CenCal Health Referral Authorization Process
www.cencalhealth.org/providers/authorizations/referrals/

H5: Medi-Reservations

"Medi-Reservation" shall mean a method of limiting the Medi-Services (or "Limited Services") allowed under the Medi-Cal program, whereby a Member is entitled only to two visits or services per month.

Medi-Reservation – SBHI & SLOHI Members

Services must be reserved by Providers for each visit to be provided. Services may be reserved by completing and submitting the Medi-Reservation Form found on the [CenCal Health](#) website. A confirmation number will be given once the Service is reserved.

Services Requiring a Medi Reservation:

- Audiology
- Chiropractic

- Acupuncture

Please check When RAF's Are Not Required on our website to determine whether a RAF is required. For more information about Medi-Reservations, please visit the [Medi-Cal website](#).

URLs for above hyperlinks:

DHCS Medi-Cal Provider
www.medi-cal.ca.gov/

H6: Decision-Making Guidelines

In general, CenCal Health uses the Department of Health Care Services, **Medi-Cal Program's** coverage guidelines for decision-making. Secondly, CenCal Health uses the **Centers for Medicare and Medicaid Services (CMS)** for decision-making. However, when Medi-Cal or CMS guidelines are non-specific or unavailable, such as for hospital stays, the Plan uses licensed **Milliman Care Guidelines (MCG)**. When none of the above sources have clear and concise guidelines, CenCal Health will research, utilize, and as needed, adopt clinical guidelines established by nationally recognized organizations and health plans that are based on sound clinical evidence for decision-making. Decisions to deny or modify a request based on medical necessity are made by MD Reviewers. The Plan reserves the right to use a board certified specialist and/or an external review organization to assist in decision-making.

For your convenience, below are guideline links to frequently requested services:

DHCS Durable Medical Equipment (DME): Oxygen and Respiratory Equipment (dura oxy)
<https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duraoxy.pdf>

DHCS Audiology and Hearing Aids (AUD)
[https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=* *a00*+OR+* *a02*+OR+* *z00*+OR+* *z02*&wFLogo=Part2+%23+Audiology+and+Hearing+Aids+\(AUD\)&wPath=N](https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=* *a00*+OR+* *a02*+OR+* *z00*+OR+* *z02*&wFLogo=Part2+%23+Audiology+and+Hearing+Aids+(AUD)&wPath=N)

DHCS Orthotics and Prosthetics (OAP)
[https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=* *a00*+OR+* *a06*+OR+* *z00*+OR+* *z02*&wFLogo=Part2+%23+Orthotics+and+Prosthetics+\(OAP\)&wPath=N](https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=* *a00*+OR+* *a06*+OR+* *z00*+OR+* *z02*&wFLogo=Part2+%23+Orthotics+and+Prosthetics+(OAP)&wPath=N)

DHCS Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories (dura bil wheel)
<https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durabilwheel.pdf>

H7: Timeliness for Authorization Request

Providers are encouraged to submit authorization requests for services in a timely manner and preferably via the [Provider Portal](#). Providers should submit their RAF, TAR (18-1, 20-1, 50-1) to CenCal as soon as possible

Routine (Standard) Request

CenCal Health shall make best efforts to process prior authorization requests promptly. However, providers should be aware that a request might pend when additional pertinent clinical information is necessary to make the coverage decision or if the request is subject to clinical review. Decisions for a routine prior authorization request are usually made within 5-14 days from receipt of the information reasonably necessary to render a decision. The decision may be deferred and the above time limit extended an additional 14 calendar days when additional clinical information is needed for review and when the member, member's requesting provider or CenCal Health can justify that an extension would be in the best interest of the member. Physician Reviewers who hold an active, unrestricted California license make medical necessity decisions. Denial or Modification notices (Notice of Action or Notice of Adverse Benefit Determination) are sent to the Provider by either fax or Provider Portal email. Members will receive denial or modification notices via U.S. mail within 3 working days of the decision.

Urgent (Expedited) Authorization Request

It is critical to allow enough time for CenCal Health to process routine requests and only submit expedited requests when truly necessary. An urgent authorization request is appropriate when a provider indicates or CenCal Health determines, that following the routine timeline could seriously jeopardize the enrollees life or health or ability to attain, maintain or regain maximum function. Urgent prior authorization requests will be processed within 72 hours of CenCal Health's receipt of the request, unless additional information is required. The decision to approve or deny an urgent request will be verbally communicated, electronically emailed via Provider Portal, or faxed to the requesting Provider and/or the member at the time the decision is rendered followed by written notice of a denial determination to the Provider and the member within 72 hours.

A request is considered urgent when a provider indicates or CenCal Health determines that, following the standard timeframe could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The Plan must make an authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for services. This timeline can be extended an additional 14 calendar days when additional supporting information is needed for decision-making.

A retroactive authorization request is not considered urgent.

Reference: Health Plan contract 08-85212, Exhibit A, Attachment 5-Utilization Management

Urgently Needed Services/Urgent care – Covered services for conditions that are not life- threatening but could result in serious injury or disability to the member unless medical attention is received.

Urgent care means an episodic physical or mental condition perceived by a member as serious but not life threatening that disrupts normal activities of daily living and requires assessment

by a healthcare provider and if necessary, treatment within 24-72 hours. Some examples include:

- Accidents and falls
- Sprains and strains
- Moderate back problems
- Breathing difficulties (i.e. mild to moderate asthma)
- Bleeding/cuts -- not bleeding a lot but requiring stitches
- Diagnostic services, including X-rays and laboratory tests
- Eye irritation and redness
- Fever or flu
- Vomiting, diarrhea or dehydration
- Severe sore throat or cough
- Minor broken bones and fractures (i.e. fingers, toes)
- Skin rashes and infections
- Urinary tract infections

Emergency Services

Emergency services are inpatient and outpatient covered services that are rendered by a provider that is qualified to provide those health services needed to evaluate or stabilize an Emergency Medical Condition. **NO AUTHORIZATION REQUIRED.**

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably expect to result in any of the following:

- Placing the patient's health (or in the case of pregnant woman, the health of the woman or unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or part.

Reference: CenCal contract 08-85212, Exhibit E, Attachment 1-Definitions

Hospital Emergency Services: In the case of an emergency medical condition, hospitals are not required to obtain prior authorization from the Plan prior to providing emergency services to members; provided, however, that upon admitting a member into hospital, the hospital should notify the Plan no later than the next business day from the date of admission. The hospital can submit an 18-1 via Provider Portal or fax an admission face sheet to CenCal Health via fax at (805) 681-3071.

Except for emergency services, coverage of all services rendered to members by the hospital is subject to CenCal Health's determination of whether such service is a covered under the applicable member benefit package. In the event it is determined that an emergency medical condition does not exist with respect to a member who presented to the hospital, the hospital needs to comply with all prior authorization requirements as set forth in this manual prior to providing any non-emergency services to a member.

Hospital's failure to obtain all required prior authorizations for non-emergency services may, in the Plan's sole discretion, result in the Plan's denial of payment for such services. Hospital shall comply with this manual and the agreement in providing non-emergency services to members. Hospital acknowledges and agrees that the Plan has the right to review the admission of any member for an emergency medical condition for appropriateness of continued stay.

H8: Hospital Discharge Follow-Up Care

Hospital shall coordinate discharge follow up services for the member in a prompt and efficient manner. Hospital shall at all times promptly and openly communicate with the member's PCP regarding the member's medical condition, including without limitation, obtaining the appropriate prior authorization should a member require additional or follow-up covered services. Hospital shall at all times promptly and openly also communicate with UM reviewer for appropriate prior authorizations needed prior to members' discharge.

H9: Referrals for Specialist Services

Except for emergent and urgently needed services; or as otherwise noted in this Manual, applicable member's benefit package, or applicable State or Federal laws; specialist shall not provide specialist services to members when there is no existing PCP referral to the specialist. The PCP needs to complete a Referral Authorization Form (RAF) via Provider Portal at when specialist care is needed for a member.

H10: Follow-Up Specialist Services

Specialist shall coordinate the provision of specialist services with the member's PCP in a prompt and efficient manner and, except in the case of an emergency medical condition, shall not provide any follow-up or additional specialist services to members other than the services indicated, duration and frequency indicated on the RAF provided to specialist by the Plan or the PCP.

Within ten (10) business days of providing specialist services to a member, specialist shall provide the member's PCP with a written report regarding the member's medical condition in such form and detail reasonably acceptable to the member's PCP and the Plan. Specialist shall at all times promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation obtaining the appropriate pre-authorization should a member require additional or follow-up covered services beyond those indicated on the RAF.

Except in the case of emergency or urgently needed services, specialist shall refer members back to the member's PCP in the event the specialist determines the member requires the services of another specialist physician.

H11: Out of Network Services

Any non-emergent or non-urgent services rendered by non-participating, non-contracted providers or facilities must be prior authorized by CenCal Health and must meet the member's medical need for specialized or unique services which the Plan considers unavailable within the existing network. The requesting provider needs to complete and submit a Referral Authorization Form (RAF) to CenCal Health for review. If CenCal Health approves the member to go out of network, the cost to the member is not greater than it would be if the service was provided in-network.

H12: Second Opinions

Members have access to a second medical opinion in any instance in which the member questions the reasonableness or necessity of the recommended procedure or questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.

If the member selects a contracting provider/specialist, the PCP may enter a RAF via [Provider Portal](#) or fax a completed RAF to CenCal Health to process the second opinion. If the member selects a non-participating, non-contracted provider/specialist or tertiary care center, the PCP still needs to enter a RAF via the Provider Portal or fax a completed RAF to CenCal Health but the provider will need to wait for an approval before the member can be referred to the non-contracted provider.

H13: New Medical Technologies

CenCal Health evaluates the necessity of coverage for new medical technologies or new applications of existing technologies on an ongoing basis. These technologies may include medical procedures, drugs and devices. The following factors are considered when evaluating the proposed technology:

- Input and coverage guidance from appropriate regulatory agencies.
- Scientific evidence that supports the technology's positive effect on health outcomes.
- The technology's effect on net health outcomes as it compares to current technology.

H14: Continuity of Care

To ensure continuity of care for members receiving services during a current episode of care for an acute condition, serious chronic condition, pregnancy, chronic mental health condition, terminal illness, care of a newborn child, or previously authorized surgery or other procedure from out-of-network providers. To transition members due to the loss of a contracted group or institutional provider. To learn more about [Continuity of Care](#) please visit the [CenCal Health](#) website.

URLs for above hyperlinks:

CenCal Health Continuity of Care Policy

www.cencalhealth.org/~media/files/pdfs/providers/for-providers/policies-and-procedures/contofcarepolicy20170710.pdf?la=en

H15: Attachment A – Authorization Guide

Form	Type of Request or Service	Who Can Submit the Request?	Purpose	Processing Timelines for URGENT Request	Processing Timelines for Routine Request
Referral Authorization Form (RAF)	Referral from PCP to Specialist, for a Second Opinion, or Standing Referral for extended care	PCP (and occasionally, designated Provider Service Staff)	To determine the medical necessity of a referral to a specialist, tertiary care center or out of network provider.	no later than 72 hours * from the receipt of referral request	within 5 working days but up to 14 calendar days*
Treatment Authorization Request (TAR) Located below are three (3) different TAR form types					
50-1	Procedures, DME, Hospice, Home Health, Elective admission request	The provider of service, e.g. DME vendor, Home Health agency. ALERT: Make sure MD has signed the order.	To determine the medical necessity of a requested service.	no later than 72 hours * from the receipt of request for service	within 5 working days but up to 14 calendar days*
18-1	Inpatient: acute, LTAC, Rehab. Concurrent or Retro review.	Admitting hospital or LTAC facility	To determine the medical necessity of continued acute care and to facilitate a transfer/transition of care	within 24 hours of admission notification or concurrent review (denial or modification, e.g. lower level of care), notify the treating provider/facility	
20-1	SNF, Subacute, CLHF	Admitting facility, hospital discharging member, PCP for Community to SNF Placements	To determine the medical necessity of continued stay in skilled nursing facilities (SNF), subacute, and congregate living health facilities (CLHF)	within 24 hours of admission notification and based on subsequent concurrent review timelines (denial or modification, e.g. lower level of care), notify the treating provider/facility	

*Can extend up to an additional 14 calendar days with an issuance of a NOA "delay".

Section I: Care Management Services

I1: Utilization Management Program

Our Utilization Management Program helps members get the best quality healthcare by assuring that medically necessary healthcare services are provided at the right

time and at the most appropriate service level or care setting covered under their benefit package. We work with our providers to evaluate services for medical appropriateness and timeliness.

- Our decisions are based entirely on appropriateness of care and service and the existence of coverage.
- We use our regulatory agencies and nationally recognized guidelines to make UM decisions.
- We do not pay, offer financial incentives, or reward our providers, employees or other individuals for denying coverage of care.
- Our utilization management staff is trained to focus on healthcare quality, medical necessity and risks of members not adequately using certain services.
- Our decisions are fair, impartial and consistent.
- We do not encourage utilization decisions that result in under-utilization.

12: Case Management (CM) Programs

CenCal Health's Case Management (CM) services are provided by registered nurses, social workers, and clinical support associates via telephone. Case Management services are offered to both adult and pediatric members. Case management programs vary depending on the needs of the member.

CenCal Health has four variations of case management services:

- Case Management
- Care Transitions
- Pediatric Whole Child Program
- Disease Management Program

Each of these programs vary in its intensity and level of service in which the program provides services to the member. Case management services are member-centered and a collaborative process that promotes quality care and cost-effective outcomes that enhance physical, psychosocial, and vocational health of individuals. It includes assessing, planning, implementing, coordinating, and evaluating health-related service options. Members may self-refer to CenCal Health's Case Management program. Referrals to CM programs can also come from a variety of sources, such as the PCP, Specialist Physician, Utilization Management team members, Medical Director, member/family, internal departments, and community based organizations. Providers may request assistance in the development of care plans for the treatment of members with complex or serious medical conditions.

To refer a member to any of our Case Management Programs, providers can complete and submit a [Case Management Referral Form](#) located at www.cencalhealth.org. The completed CM Referral Form may be faxed to (805) 681-8260 or the provider can call the Health Services Central Line at (805) 562-1082, option # 2 to obtain assistance with referring a member. The CM department will acknowledge referral and providers will be informed of the member's appropriateness for CM services. Once CM determines a member is appropriate for

case management services and the member or authorized representative agrees to the service, CM will begin to work collaboratively with the member, the member's family, physician(s), and other healthcare professional(s).

URLs for above hyperlinks:

Case Management Referral Form <https://www.cencalhealth.org/providers/case-management/>

I3: Case Management

CenCal Health's Case Management Program provides traditional Case Management services in which case managers, who are nurses or social workers, follow members who meet certain conditions. The Case Manager works collaboratively with the member and their PCP, specialist and other members of interdisciplinary care team to assist the member with coordinating care and to attain member-centered goals.

Case Management Services are available to members who:

- Have complex or chronic medical conditions, including those affecting multiple organ systems or complicated therapy that warrant closer monitoring (e.g. CHF, uncontrolled diabetes, transplants, cancer, exacerbating asthma, ESRD or COPD),
- Have suffered a traumatic/ catastrophic injury or illness.
- Is non-adherent to medical or treatment regimen (e.g., two or more missed appointments, misuse of medications, poor dietary adherence).
- Are high utilizers of EDs (e.g., two visits in three months).
- Over/under utilize medical services that are available to them.
- Have frequent hospital admissions (same or different diagnosis) and readmissions. (within thirty days of discharge) for ambulatory care sensitive conditions such as diabetes, asthma, congestive heart failure, hypertension (e.g., four hospital admissions in one year).
- Need coordination of care for medically necessary services outside of the provider network.
- Require assistance following a particular medical regimen (e.g., pre-surgical). Have self-care deficits requiring one-to-one or group health education to promote well-being.
- Have high psychosocial risk factors that have or can result in significant negative health outcomes.
- Assistance with coordination to community resources (e.g. Food Bank, Meals on Wheels, Family resource Centers, and/or Unity Shop)
- Members with fragile conditions, including cognitive changes needing assistance with care coordination or care transitions.

- Require care coordination with specialized programs, such as Local Education Agency, Regional Centers and County Mental Health.

- Members who need transition from one care setting to another (e.g. from acute care facility to skilled nursing facility (SNF), SNF to home or other alternative living situations, home to SNF, and non-contracted to Contracted SNF)

CenCal Health's CM program includes physical and psychosocial assessment, planning, facilitation, care coordination, evaluation and advocacy for service and support options to meet a member's and/or their family/representative's comprehensive healthcare needs to promote quality and cost-effective outcomes. The complexity and intensity of the member's needs determines the level of service. The CM team not only provides education materials and encourages the member to learn self-management skills; they also coordinate access to appropriate services and resources.

A Case Manager will work with the Provider, the member and the member's family in an effort to help decrease the risk of complications, support coordination of care and provide education. The Case Manager will work with Providers to assess, plan and monitor options and services for members with chronic illness or injury.

14: Care Transitions

CenCal Health's Care Transition program consists of facilitating the movement of members from one care setting (e.g. from acute care facility to skilled nursing facility (SNF), SNF to home or other alternative living situations, home to SNF, and non-contracted to Contracted SNF). The Care Transition program differs slightly depending on the member's current care setting. The goal of this program is to improve transitions of care for our members by improving quality of care and avoid preventable readmissions.

For members in the acute care and acute rehabilitation setting, the Utilization Management (UM) team works collaboratively with the hospital discharge planners/case managers to facilitate the move of the member to an alternative care setting.

For members in a SNF; subacute; Congregate Living Health Facility (CLHF) long-term care, assisted living, board and care or residing at home, the Case Management (CM) team is involved with facilitating the move of the member to an alternative care. Depending on the need of the member, a CM Nurse or CM Social Worker works with the member, their family/caregiver, and/or facility staff to facilitate the transition of a member while allowing the member to maintain or attain a living arrangement that is the least restrictive to meet their needs.

15: Pediatric Whole Child Program

The Pediatric Whole Child Program has dedicated nurses and nonclinical professionals who assist providers with timely processing of necessary specialty referrals and service requests, as well as provide care coordination and care transition services to members. The Pediatric Program is designed as a "one-stop shop" for providers to obtain covered services for children and youth under the age of 21. The Pediatric team is comprised of a group of specialized staff who perform

both utilization review and case management activities. Similar to CenCal Health's Adult Case Management Program, pediatric care coordination and care transition services are dependent on active family and/or caregiver participation.

The Pediatric Team processes, facilitates, and/or coordinates:

- Referrals (RAF)
- Prior authorization requests (50-1, 18-1, 20-1)
- Care coordination of healthcare services or with specialized programs, such as CCS, TCRC, LEA, etc.
- Care transition from one setting to another
- Individualized (or family) guidance, education, community resources

Providers can refer a child or youth under the age of 21 to the Pediatric Whole Child Program case management the same way they would refer an adult to case management or care transitions. Complete a CM Referral Form found at www.cencalhealth.org, under the Provider tab. Authorization requests (50-1, 18-1, 20-1) and referrals (RAF) are also submitted the same way as for adults, via the [Provider Portal](#).

Section J: Disease Management Programs

J1: Disease Management

CenCal Health offers three disease management programs:

- Diabetes Condition Support
- Heart Condition Support
- Substance Use Disorder Condition Support

All programs provide a comprehensive, ongoing, and coordinated approach to achieving desired health outcomes.

These outcomes include improving patient's clinical condition and quality of life.

CenCal Health disease management programs help facilitate patient's care, and also offer, support to care providers.

Benefits include:

- Access to patient specific condition monitoring
- Collaboration to support treatment plan
- Assistance in educating patients on self-management (which includes prevention of disease exacerbation and complications)
- Use of evidence-based practice guidelines in program content

CenCal Health members who qualify for disease management program support are enrolled in these programs and may opt out of the program at any time.

Interventions are based on severity level and include, but are not limited to:

- Enhanced health education for all members (welcome packet containing health education and program information)
- Telephonic health coaching from a nurse

- Care coordination support
- Community resource referrals

CenCal Health Diabetes, Heart Disease and Substance Use Disorder Management Program Eligibility

Who is eligible?

- CenCal Health Members

And

- Diagnosis of diabetes mellitus, heart disease or substance use disorder

If you want to refer a new patient or confirm a patient is in the program call CenCal Health Disease Management Department (805)364-9330.

J2: SMART Programs

SMART is an acronym for Successful Management Always Requires a Team, which highlights the importance of care coordination activities, and the support of the entire care team in facilitating good medical outcomes for patients. The SMART programs are designed to encourage provider adherence to evidence-based and well-established clinical guidelines for treatment of chronic health conditions. CenCal Health automatically identifies and enrolls members into the Breathe SMART and Diabetes SMART Programs through internal data reporting systems.

Please note that all SMART Programs will be retired in 2022.

J3: Breathe SMART Program

CenCal Health's Breathe SMART Program is a PCP pay-for-performance program for members diagnosed with clinically persistent asthma.

The goal of the Breathe SMART Program is to promote and facilitate patient-physician communication to reduce asthma exacerbations by encouraging asthma medication adherence.

Program Components: The Breathe SMART Program is structured to support the management of members' asthma by their PCP. The components of the program include:

- Promotion of Asthma Action Plans
- PCP reports on preferred and rescue medication usage
- PCP reports to identify patients with Emergency Department or inpatient stays
- Notification to PCPs of high risk members with persistent asthma

Provider reports regarding members enrolled in the Breathe SMART program are available to PCPs on CenCal Health's Provider Portal.

Pay for Performance – Requirements & Metrics

A \$100 incentive is paid annually to PCPs for each member who filled eight or more preferred asthma controller medications on different dates of service during the calendar year.

J4: Diabetes SMART Program

CenCal Health's Diabetes SMART Program is a disease management program for members diagnosed with diabetes.

The prevailing clinical treatment guidelines, maintained by the American Diabetes Association (ADA), are the foundation of CenCal Health's Diabetes SMART Program. *The goal of the Diabetes SMART Program is to increase utilization of vital clinical services in accordance with the ADA's prevailing evidence-based clinical treatment guidelines.*

CenCal Health identifies diabetic members and provides their PCPs with tools to optimally manage this chronic condition. An objective of the program is to promote and facilitate patient-physician communication to better ensure medical services are provided in accordance with best clinical practices.

Program Components: The Diabetes SMART Program is structured to support the management of members' diabetes care by their PCP. The components of the program include:

- Diabetes education materials for members upon request
- Notification to PCPs of members newly enrolled in the Diabetes SMART program
- Notification to PCPs of members in need of clinical screening related to diabetes care
- Notification to PCPs of high-risk diabetic members
- PCP quality performance reporting regarding their diabetic population
- An online tool to submit clinical data and to manage members enrolled in the Diabetes SMART Program via the web portal

Data Sources: CenCal Health receives clinical tests and their results from multiple sources including claims submission, laboratory biometric data uploads, and supplemental provider reporting.

Reports: All provider notifications regarding members enrolled in the Diabetes SMART program and PCP quality performance is communicated through monthly reports that are updated on the Provider Portal.

Pay for Performance: A \$50 incentive is paid to PCPs for each assigned diabetic member who annually completes three key services that are recommended by the ADA's established clinical guidelines. These services comprise a set of "Minimum Clinical Services"¹. Multiple services, when medically necessary, are encouraged for each of the following Minimum Clinical Services:

- Hemoglobin A1c testing (HbA1c)
- Diabetic Eye Exam
- Treatment or screening for nephropathy

An additional \$25 incentive is paid for clinical improvement in HbA1c tests that show a 10% reduction from the 1st baseline test within a calendar year. A maximum of 3 clinical improvement incentives are available per member, per year. As many HbA1c tests as are medically necessary are separately reimbursable on a fee-for-service basis.

Increased utilization of screenings is encouraged, as medically necessary to effectively control each member's diabetes, consistent with the ADA's clinical recommendations. Accepted screenings include those defined by the ADA and the prevailing NCQA clinical quality measurement specifications.

¹ LDL cholesterol was retired in 2017 from the Diabetes SMART Program MCS grouping and clinical improvement calculations, to align with the prevailing ADA clinical treatment guidelines.

J5: Substance Use Disorder Program

The Substance Use Disorder Disease Management Program's concentration is to assist with navigating the process of accessing treatment for substance use disorder and in addressing medical conditions. Once enrolled a Registered Nurse will complete assessments with the member to determine their needs and to identify goals. The members will then collaborate with the RN for purpose of improving their quality of life and learn how to manage their condition. Most interactions between the RN and the member will be conducted via telehealth. This is a voluntary program and CenCal Health provides care management in collaboration with local agencies for whole person care.

Program Goal:

- To reduce the stigma of having a substance use disorder with the understanding that the individual did not choose to have this condition, however they can choose recovery.
- To provide support for our members through their journey of recovery; and to empower them to take back control of their lives and to gain freedom from their Substance Use Disorder.

Program Objectives:

Support and guide the member to take ownership of their recovery.

Provide education:

- On the disease process of substance use disorders, including signs, symptoms and treatment options
- On accessing lifesaving medication and instructing them in its appropriate use
- On options for Medication-Assisted Treatment (MAT) and identifying a willing provider
- On MAT through pregnancy, when appropriate, to increase the chance for a healthy pregnancy
- For family members on substance use disorders and resources for support groups, with the members permission
- The importance of coordinating care between providers.
- On appropriate use of the Emergency Department; and identifying conditions that can managed through PCP and/or specialist visits; or directed to an urgent care

Assist members:

- To seek providers, as appropriate, to identify and treat co-morbidities and co-occurring disorders
- To seek peri-natal care and identify providers
- In compliance with physician directed treatment plans and prescription medications

What services can the SUD Program provide?

- Assistance with medication management
- Coordination of care between providers, when appropriate
- Assistance with follow-up visits to healthcare providers
- Education to maintain health and recovery, focusing on whole person care
- Linkage to community resources
- Substance use disorder education
- Encourage self-management of substance use disorder recovery
- 24-Hour Nurse Advice Line

To be eligible for the SUD program, members must be:

- Age 18 or older
- A CenCal Health member
- A primary substance use disorder; or a primary medical diagnosis that is caused or exacerbated by a secondary substance use disorder.
- Willing to participate in the care plan and care services

Referral Process to the SUD program:

Referrals can be made:

- Internally – by a CenCal Health employee
- Externally – by a Provider in the community
- Self-referral – by direct contact with the Disease Management Department or through Member Services

Section K: Claims and Billing Guidelines

K1: Claims Billing

CenCal Health follows the Medi-Cal guidelines and benefits outlined in the Manuals published by the State of California, with a few exceptions. Please see Benefits and Exclusions information for specific programs found in the Benefits Summary section of this Provider Manual. For specific claim questions, we recommend you contact your Claims Customer Service Representative. The address and telephone number for the Claims Customer Service Team is listed at the end of this section.

Below is a listing of bullet points outlining the general billing requirements. Bullets apply to all programs, except where specific programs are indicated:

- Claims may be submitted electronically (HIPAA compliant format), through a clearing-house, via our Website at www.cencalhealth.org, or on a hard copy claim form.
- “Clean” claims will be reimbursed within 45 working days of receipt. Clean claims are claims that include all of the necessary and accurate and valid data for adjudication. This includes, but is not limited to, name, gender, date

of birth, subscriber number of member; ICD-10 diagnosis code(s), CPT/HCPCS codes, modifiers, billed charges, applicable authorization numbers, place of service, quantity of services, bill type and the NPI – National Provider Identification number.

- For Contracted Providers, claims payment is payable at the contracted rate. Payment will not exceed billed charges unless specifically stated in the contract.
- For Non-Contracted Providers, claims payment is payable at the Medi-Cal rate; additionally, payment will not exceed billed charges.

Member administrative fees or surcharges: Under no circumstances whatsoever may a Provider collect or attempt to collect fees from a CenCal Health Member (Medi-Cal beneficiary) for any non-clinical or administrative services, including but not limited to fees for: enrollment or subscription, appointment access, filling out forms or prescriptions, or for late arrival or absence from an appointment (also known as “no-show” fees). Providers must refer any CenCal Health Member who is habitually late to or absent from appointments to CenCal Health’s Member Services department. CenCal Health will follow-up with the Member and provide any education or outreach needed. Providers must immediately return any such collected fees to the Member, and may be subject to termination from the network for violating this policy. Any such fees not returned to the Member may be withheld from future claim payments to the Provider.

Ambulatory Surgery Centers and Surgical Implant Billing: For Ambulatory Surgery Center (ASC) facilities in the CenCal Health network that are paid according to Medicare rates, it is acknowledged that Medicare typically bundles in the value of surgical implants to the global facility fee paid to ASC facilities. The ASC fee is thusly inclusive of the cost of those surgical implants.

CenCal Health has identified a list of surgical Implant Procedures (below) involving the use of implanted devices and associated supplies, whose value is included in the Medicare ASC fee schedule rate paid by CenCal Health, including but not limited to:

Implant Procedure	Associated CPT Procedure Codes
Joint Replacement Surgery	27446, 27447
Pacemakers	33206, 33207, 33208, 33212, 33213, 33214, 33221, 33227, 33228, 33229
Defibrillators	33230, 33231, 33240, 33249, 33262, 33263, 33264, 33270, 33271
Cardiac Event Recorders	33282
Infusion Pumps	62360, 62361, 62362
Neurostimulators	61885, 61886, 63650, 63663, 63664, 63665, 63685, 64568, 64575, 64580, 64581, and 64590
Cochlear Implants	69930

Implants and supplies billed by ASC facilities in conjunction with the above Implant Procedures are not eligible for separate reimbursement if the facility is reimbursed at Medicare rates. The Associated CPT Procedure Codes are provided as a reference – any changes to CPT codes associated with the Implant Procedures described above may be incorporated to this policy at any time, at the sole discretion of CenCal Health.

Whole Child Model (WCM) and California Children's Services (CCS)

Effective July 01, 2018, CenCal Health assumed the responsibility of both Santa Barbara and San Luis Obispo counties for the Utilization and Claims payment for CCS eligible members that reside in these counties. Providers must be CCS certified for the specialty services they render.

Standard CenCal Health claim submission, claim correction, dispute/appeal, and timely filing requirements as outlined elsewhere in the Provider Manual and on our website also apply to claims for CCS services rendered to CenCal Health members.

Baby/NICU services may need to be billed using the mother's Member ID for the first two months of life beginning with the month of birth and ensure the correct relationship code is utilized.

Please visit the CenCal Health website for additional Claims and Billing Guidelines or the Medi-Cal Manual.

Denied Claims

Providers are requested to review denial explain code(s) and correct denial(s), and rebill the claim for further consideration of payment. CenCal Health must receive any corrections within 6 months from the date of the Explanation of Payment on which the claim originally appeared. Any corrections received after the end of the sixth month will not be considered.

Disputes

If you do not agree with any decision made by CenCal Health with respect to payment or denial, you may dispute the decision. Submit a Dispute Form with all the information, including any attachments/documentation, for consideration of payment within 6 months of the initial EOP date. The appropriate staff member will review your dispute and you will be informed of the decision, in writing, within 45 working days of receipt of the dispute. This applies to all CenCal Health programs.

Appeals

An appeal may be submitted to contest the processing, payment or non-payment of a previously submitted dispute. Providers must submit in writing within 90 days of the action/inaction precipitating the complaint. Failure to submit an appeal within this 90-day period will result in the appeal being denied.

CONTACT INFORMATION FOR CLAIMS:

Submit Original Claims to:
CenCal Health
P.O. Box 948
Goleta, CA 93116-0948

Send Claims Inquiries, Disputes, and Appeals:
CenCal Health
Attention: Claims Department
4050 Calle Real
Santa Barbara, CA 93110

Telephone Claim Inquiries:
805-685-9525 ext. 1083
800-421-2560 ext. 1083

K2: Payment Procedures for CenCal Health Members

Billing and Payment for Inpatient Services

A day of service is billed and reimbursed for each Member who occupies an inpatient bed at 12:00 midnight in the Hospital facility. Regarding a newborn, the mother's ID number may be used for the baby for the month of birth and through the end of the second month following birth. Once a newborn is assigned his/her own Medi-Cal identification number, that number will be used on all future claims and the mother's ID can no longer be submitted.

Hospital should not separately bill for outpatient, urgent care, and emergency services provided to a Member within twenty-four (24) hours of the admission of the Member to Hospital when the foregoing services are directly related to the condition(s) for which the Member is admitted to Hospital.

Claims Submission Timeliness

Providers shall bill CenCal Health for medical services on the UB-04 or its successor, on the CMS-1500 or its successor, or in an electronic format using industry standards as specified by CenCal Health and/or Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed by the parties. In order to qualify for full payment, Hospitals should submit the claims form to CenCal Health within one hundred and eighty (180) days from the date of service for professional/outpatient claims. Claims received in the 7th to 9th month from the date of service will be paid at 75% of the allowable, and claims received in the 10th to 12th month from the date of service will be paid at the 50% of the allowable.

Claims that are submitted after one year from the date of service will not be considered without a valid reason for the delay.

The providers shall comply with existing State and Federal law and regulations pertaining to the issuance of explanations of payment (EOP's) for CenCal Health Members. Additional information on EOP's can be found in the Claims Section of this Provider Manual.

Providers shall be aware that any other health program (including Medicare) must be billed and recoveries made prior to billing State programs. Such rules shall also apply to CenCal Health's administration of the Medi-Cal Program. If CenCal Health receives a claim and determines that another insurance has been, or should have been billed, CenCal Health shall process such claims, reduce payment, or deny claims as appropriate, with notice of such reduction or denial indicated on the EOP. See proceeding section on Other Health Coverage (Section K3).

Claims Processing

CenCal Health will receive and process a clean claim in a timely manner and according to standards set forth in the Hospital Services Agreement, the EDS manual or in this Provider Manual.

Payment Requirements/Responsibilities with the Prudent Layperson Standard for Emergency Services

The determination of whether the prudent layperson standard was met, as defined in the definition of Emergency Services, Article 1, Definitions, of the Agreement, and in the AUTHORIZATIONS section of the Provider Obligations section of this Provider Manual will be made on a case-by-case basis. Except that CenCal Health coverage may be based on diagnosis code and may set reasonable claim payment deadlines.

CenCal Health may not deny coverage solely based on diagnosis code(s), nor deny coverage of this basis and then require submission of the claim as part of an appeal process. Prior to denying coverage or modifying a claim for payment, CenCal Health will determine whether the prudent layperson standard has been met on the basis of all pertinent documentation, with focus on the presenting symptoms (and not on the final diagnosis). Additionally, CenCal Health will take into account that the decision to seek Emergency Services was made by a prudent layperson (rather than a medical professional).

Emergency Room, Urgent Care, and Treatment/Exam Room Claims Processing

Hospital should follow the general guidelines as indicated in the Claims Section of this Provider Manual when billing these claim types.

Inquiries and Appeals Regarding Claims Processing and/or Payment

If the Hospital has an inquiry or an appeal concerning the processing or payment of its claims by CenCal Health for services provided, CenCal Health has established procedures to accommodate the Hospital's desire to have its inquiry or appeal heard, evaluated, and resolved.

K3: Other Health Coverage (OHC) and SBHI & SLOHI

A person covered under CenCal Health's Santa Barbara Health Initiative (SBHI) or San Luis Obispo Health Initiative (SLOHI) may also have other private/group health insurance. Having private/group health insurance does not affect a member's SBHI/SLOHI/Medi-Cal eligibility in any way.

However, if you are not a participating provider of a recipient's Other Health Coverage (OHC), you should advise the member to obtain services through his other insurance or Health Maintenance Organization (HMO) Primary Care Physician (PCP), or refer them to a provider who participates in that plan. For instance, if you are the member's PCP through SBHI or SLOHI but not the member's PCP through Blue Cross HMO, you should refer the member to his Blue Cross HMO or obtain a treatment authorization from the HMO. CenCal Health will not reimburse for services not authorized by the HMO. If you are not an authorized provider of the recipient's HMO, please refer the member to his HMO and/or ask the member to contact the CenCal Health Member Services Department to reselect a PCP who participates in both programs.

K4: Billing for Members Who Have Other Coverage

State law mandates Medi-Cal to be payer of last resort, and requires the utilization of other available healthcare coverage prior to the utilization of Medi-Cal. Other coverage is always the primary payer and cannot be waived by the member. We ask that you always bill the member's other coverage first prior to billing SBHI or SLOHI Medi-Cal. If the other coverage denies payment, a copy of the Explanation of Payment (EOP) or denial letter must be sent with your claim to CenCal Health.

Providers are required to notify CenCal Health if they believe a member may be entitled to health coverage through a private/group health insurance plan or policy that is not indicated on the member's eligibility record. Providers should call CenCal Health's Finance Department, Recoveries Unit at (805) 562-1081 to report possible other insurance coverage. Providers are prohibited from billing members' other insurance copayment amounts for Eligible Members with Other Coverage.

If the member has other health coverage, claims must be received within 60 days from the date of the EOP from the other health carrier to be considered for full payment. Claims received after 60 days from the EOP date fall back to Medi-Cal Submission and Timelines guidelines.

K5: What You Should Know About Medicare HMOs

The Other Health Coverage code "F" identifies Medi-Cal members who receive benefits from Medicare-contracted Health Maintenance Organizations (HMO) in lieu of the fee-for-service Medicare plan. Members who have both Medi-Cal coverage and Medicare HMO coverage must seek medical treatment through the Medicare HMO first. SBHI and SLOHI Medi-Cal will not pay for the HMO-covered services if the patient elects to go to a non-participating plan provider for care. However, SBHI and SLOHI Medi-Cal will reimburse for services which are Medi-Cal covered benefits but which are not covered by the Medicare HMO plan.

Medi-Cal claims for members with Medicare HMO coverage are not Medicare/Medi-Cal crossover claims (see below). Therefore, to bill Medi-Cal for services not included in the Medicare HMO plan, submit a Medi-Cal claim accompanied by a Remittance Advice (RA), Medicare Remittance Detail, or denial letter showing that the Medicare HMO was billed first.

K6: Medicare/Medi-Cal Crossover Claims

Claims for members who are eligible for both Medicare and Medi-Cal coverage must be billed to Medicare (either electronically or on paper) prior to billing Medi-Cal, with the exception of Medicare non-covered services. A list of Medicare Non-Covered Services can be found in the Medi-Cal manual under "medi non cpt" and "medi non hcp." SBHI and SLOHI Medi-Cal may reimburse providers for the Medicare deductible and coinsurance. A claim for Medicare deductible and coinsurance amounts is called a crossover claim.

The California Welfare and Institutions Code (WIC) limits Medi-Cal payments of the deductible and coinsurance to an amount which, when combined with the Medicare payment, should not exceed the amount paid by Medi-Cal for similar services. The combined Medicare/Medi-Cal payment for all services of a claim may not exceed the amounts allowed by CenCal Health.

Providers who accept a patient who is eligible for both Medicare and Medi-Cal cannot bill the member for the Medicare deductible and coinsurance amounts; these amounts can be billed to SBHI/SLOHI/Medi-Cal. However, the provider should bill the patient for his/her share of cost, if any. Providers are encouraged to wait until they receive the Medicare payment prior to collecting the share of cost to avoid collecting amounts greater than the Medicare deductible and/or coinsurance. Please note: CenCal Health lifted the Referral Authorization Form (RAF) requirement for crossover services. RAFs are still required for non-Medicare benefits for which Medi-Cal will be the primary payer.

SBHI and SLOHI Medi-Cal now accept crossover claims electronically. Claims submitted to Medicare electronically will automatically crossover to SBHI/SLOHI for processing. These claims should appear on your SBHI/SLOHI EOP within four to six weeks. If your claim has not appeared on an EOP within this timeframe, contact your Claims Representative for further assistance.

If you have any questions about what other coverage a member has, what carrier to bill first, Other Health Coverage codes or third party coverage questions, please contact the Recoveries Unit at (805) 562-1081.

Section L: Quality Management

L1: Quality Improvement System

CenCal Health is firmly committed to the delivery of quality healthcare services to its membership. The purpose of CenCal Health's Quality Improvement System is to define a process to continuously improve the quality of care, quality of service, patient safety, and member experience provided by CenCal Health and/or its contracted provider network. This includes actions to monitor, evaluate, and take effective and timely action to address any needed improvements in the quality of care delivered by CenCal Health providers rendering services in any setting. The QI process is described in detail below:

- Define the scope of quality of care, quality of service, patient safety, and patient experience.
- Establish staff accountability for monitoring and evaluating quality improvement activities.
- Use measurable indicators to systematically monitor aspects of care, service, safety and patient experience, based on current and proven industry-standard methodologies.
- Identify comparable benchmarks and/or thresholds and goals for monitoring of meaningful, industry-standard, performance indicators.
- Sustain quality of care and service when benchmarks and/or goals are achieved, or identify opportunities to improve when measurements fall outside thresholds.
- Evaluate barriers that are directly associated with continued improvement, and assess the potential for CenCal Health to mitigate each barrier and resolve identified problems.
- Based on identified barriers, design relevant, strong and timely interventions and take action to correct identified barriers.

- Systematically evaluate the effectiveness of those actions using relevant and reliable measurements.
- Communicate results to the appropriate committees and stakeholders, including but not limited to CenCal Health's Board of Directors.
- At appropriate intervals re-evaluate performance using comparable measurements; assess performance relative to benchmarks and goals; and identify remaining barriers, if any. Based on findings implement new and/or improved interventions as necessary.

To assure appropriate resource allocation to support the quality function, an organization-wide Quality Program Work Plan and Assessment are developed annually in congruence with CenCal Health's Quality Program and CenCal Health's Strategic Plan. An annual assessment is undertaken to systematically evaluate progress made toward the work plan of the prior year. The assessment assures CenCal Health identifies areas of success and opportunities for improvement in the coming year. Those identified opportunities are used to plan new activities or refine existing ones in order to prospectively refine the Quality Improvement System. The Work Plan serves as a roadmap of specific quality improvement objectives and it establishes staff accountability for key activities in the coming year. To assure successful performance of the Quality Improvement System, with the annual development of CenCal Health's Quality Program Work Plan, CenCal Health's leadership sets appropriate goals and objectives for staff.

For additional information, please reference the [CenCal Health Quality Program](https://cencalhealth.org/providers/quality-of-care/quality-program/)
cencalhealth.org/providers/quality-of-care/quality-program/

L2: Quality of Care (QOC) Review Process

CenCal Health is committed to ensuring our members receive appropriate medical care and services. CenCal Health has a process to identify and investigate potential quality of care issues (PQOC) and initiate corrective action when appropriate. This helps to continually improve the quality of care delivered to our members.

While PQOC sources include but are not limited to:

- Calls from members, which are the most significant source of complaints. Members can contact our toll free number (877) 814-1861 or can submit a complaint in person or in writing.
- CenCal Health's contracted providers, community agencies/liasons (CCS, APS, hospital case managers) may submit potential quality of care concerns to populationhealth@cencalhealth.org.
- Any of CenCal Health's staff may identify PQOCs and submit them to populationhealth@cencalhealth.org.

Review Process

The assigned QOC review nurse or designee will determine whether the complaint includes any clinical component, and if so initiates a review as follows:

- Relevant medical records are obtained including provider chart notes, ED records, Pharmacy Profile, and a response from the provider when appropriate.

- Additional review or a focused site survey may be required if the medical records, pharmacy, or claims profiles are insufficient to answer all clinical issues or concerns.
- CenCal Health's Medical Director/Physician Designee determines if the clinical care met medical standards or was a deviation from standard of care, according to established evidence-based clinical guidelines or community standards. The Medical Director will consult with expert clinical specialists if applicable.
- If a deviation from standard of care is suspected, the Medical Director/Physician Designee will contact the provider involved to discuss the concern directly. Formal provider interaction may be undertaken to complete the investigation and assure due process as indicated.
- The Medical Director may forward quality of care issues to the Peer Review Committee for additional review and determination.
- Opportunities for improvement of care will be shared with the provider and may include a formal corrective action plan that is appropriately customized to the level of significance of the clinical concern.
- In some instances, ongoing monitoring of providers may be required to assure that clinical practices continue to meet standards of care.
- All medical record documentation, investigations, outcomes or allegations are held strictly confidential by CenCal Health. No portion of the information related to the investigation is shared with anyone not authorized to review the information.

L3: Quality Performance Reporting

Contracted Providers are required to participate in CenCal Health's quality improvement activities. Such activities include but are not limited to those set forth in CenCal Health's Quality Program Description, including utilization and care management programs, Managed Care Accountability Set data collection, Performance Improvement Projects (PIPs), or other quality improvement measures, policies, or processes.

Providers receive information relating to CenCal Health's quality of care through methods including but not limited to summaries and/or announcements in provider bulletins, site visit reports, presentation of results to providers that participate on committees that comprise CenCal Health's quality committee structure, and on CenCal Health's website.

Members receive information through methods including but not limited to summaries and/or announcements in member bulletins and on CenCal Health's website.

Providers and members may also request a hardcopy of CenCal Health's quality performance results by calling the Quality Measurement team at 800-421-2560 extension 1609.

L4: Quality Care Incentive Program

The Quality Care Incentive Program serves to identify members who are due for clinically recommended aspects of care to further assist PCPs in providing comprehensive high quality health care for members.

Performance & Payment Methodology

Performance measurement methodology is equally applied for all capitated PCPs, including but not limited to Federally Qualified Health Centers and Rural Health Centers. Incentive payments are not paid as an additional rate per service or visit. PCP performance is measured against pre-defined, industry-standard, clinical measures. Measurement results are calculated using NCQA-certified HEDIS® reporting software.

Measures:

Quality of care categories and measures are systematically identified for inclusion in the program based on the following criteria:

- Areas of needed quality improvement for CenCal Health
- The feasibility of accurate quality of care measurement utilizing claim, lab, and registry data
- A balanced distribution of adult and pediatric measures
- A balanced distribution of disease management and preventive care measures
- Alignment with state-wide recommended quality focus areas

The quality of care categories and measures are evaluated on an annual basis to ensure that the above criteria are met. As priorities regarding these criteria change, CenCal Health may update these categories and measures. Categories and measures will be changed no less than annually.

Payment:

Payment performance is calculated, expressed, and reported for each priority measure and all combined priority measures.

- Individual PCP measure performance is calculated as a percentage, based on the numerator divided by the denominator, for each qualifying measure.
- A PCP's overall performance is based on the sum of all measure numerators divided by the sum of all denominators for all measures for the PCP.
- Performance is expressed using a 5-star performance scale (quintile).
- Star ratings (quintiles) are assigned for each measure, and for all measures in aggregate, by:
 - Ranking PCPs in descending order by their aggregate performance percentage
 - Stratifying the population by quintile, each containing an equal number of PCPs
 - Assigning stars to each quintile -- 5 stars to the highest performing quintile, 4 stars to the next lower quintile, etc.
- If multiple PCPs have the same aggregate clinical score and PCPs are separated into different quintiles, PCPs with equal scores will be included in the higher quintile.
- PCPs earn incentives according to the number of stars earned:

- Quintile 5 = 5 stars = 100% of total pool
- Quintile 4 = 4 stars = 80% of total pool
- Quintile 3 = 3 stars = 60% of total pool
- Quintile 2 = 2 stars = 40% of total pool
- Quintile 1 = 1 star = 20% of total pool
- PCP incentive payments will be completed quarterly reflecting the prior twelve (12) months of performance, with each payment calculation period rolling forward by a quarter.
 - PCPs who have less than 30 members in all priority measures combined do not qualify for program payment at the time of quarterly payment calculations. They will receive 25% of their capitation withhold at that time of payment.

Quality Measures

Identified quality measures encompass aspects of care that PCPs can influence either through direct care or through referral to specialists or other ancillary practitioners. Identified priority measures are consistent with accepted clinical guidelines and clinically relevant to CenCal Health's membership. Quality of care measures are comprised of six (6) clinical categories of care:

- Behavioral Health
- Women's Health
- Pediatric Care
- Diabetes Care
- Respiratory Care
- Cardiac Care

The quality measures included in each category may be found in the [Quality Care Incentive Program Measures](#). All measure specifications reflect the prevailing NCQA HEDIS® Volume 2 Technical Specifications and are updated as measure specifications change. Generally, measures remain within the Quality Care Incentive Program for at least two (2) years to reinforce improvement priorities and expectations, support program stability for PCPs, and increase the potential to achieve overall network performance that meets or exceeds external benchmarks of clinical excellence.

Quality Care Incentive Program Performance Reporting

Quality Care Incentive Program performance reporting occurs on a monthly basis for all PCPs. Reporting information is available to PCPs via the Provider Portal on CenCal Health's website, www.cencalhealth.org, in the Quality Care Incentive Program module. Quality Care Incentive Program Performance reporting is broken up into three (3) sections: the Quality Care Incentive Program Dashboard, the Quality Care Incentive Program Performance Overview, and

the Quality Care Incentive Program Financial Overview. For detailed instructions regarding navigation of the Provider Portal screens, please go to cencalhealth.org/providers/provider-training-resources

Quality Care Incentive Program Dashboard

The Quality Care Incentive Program Dashboard is a snapshot trended view of both a PCP's overall program performance and their overall financial performance. This page can be filtered by time-frame.

Quality Care Incentive Program Performance Overview

The Quality Care Incentive Program Performance Overview displays quality scoring for each PCP's membership. It includes:

- The PCP's trended performance which can be filtered by:
 - PCP location as applicable
 - CenCal Health identified quality measures for improvement
 - Priority quality measures (those that are incentivized have an asterisk next to them)
 - County of service
 - Time-frame
- The PCP's quality performance score by month is reflected on the trend line and performance rates can be displayed by hovering over the trend line marker.
 - Each trend line marker can be clicked on to display that month's performance detail on the Quality Care Incentive Program Provider Summary Detail screen. It includes:
 - Number of members in each measure category
 - Number of compliant members in each measure category
 - By clicking on the number in this field you can drill into member detail
 - Number of non-compliant members in each measure category
 - By clicking on the number in this field you can drill into member detail
 - Measure category rate
 - Number of members in each measure
 - Number of compliant members in each measure
 - By clicking on the number in this field you can drill into member detail
 - Number of non-compliant members in each measure
 - By clicking on the number in this field you can drill into member detail
 - Measure rate
 - Number of overall members in the program
 - Number of overall compliant members in the program
 - By clicking on the number in this field you can drill into member detail
 - Number of overall non-compliant members in the program
 - By clicking on the number in this field you can drill into member detail

- Overall program rate
- All member detail information includes the following fields: member ID number, member name, member date of birth, member age, member gender, member phone number, measure category, and measure name
 - You can click on the member's ID number to view the Member 360 screen.

Quality Care Incentive Program Financial Overview

The Quality Care Incentive Program Financial Overview displays each PCP's trended incentive payments as well as the trended incentive funding available to them. It includes:

- The PCP's trended financial payments performance which can be filtered by:
 - PCP Location as applicable
 - Time-frame
- The PCP's financial payment performance by quarter is reflected on the trend line, and payment amounts can be displayed by hovering over the trend line marker.
 - Each trend line marker can be clicked on to display that quarter's payment detail on the Quality Care Incentive Program Payment Scoring Detail screen.
 - Quality Care Incentive Program Payment Scoring Detail includes:
 - Incentive Date
 - Vendor ID
 - Provider NPI
 - By clicking on the number in this field you can drill into the payment detail which includes:
 - Incentive date
 - Vendor ID
 - Provider NPI
 - Total Incentive Payment
 - Member ID
 - Member Name
 - Member Date of Birth
 - Measure Name
 - If the member triggered an incentive payment
 - Provider Name
 - Performance Percentage Rate
 - Quintile in which the provider fell(i.e. Stars Earned)
 - Capitation Withhold Amount
 - CenCal Contribution Amount
 - Total Financial Pool Available Amount
 - Percentage of Financial Pool Available Earned

- Total Incentive Payment Amount

Program Support

CenCal Health's Population Health and Provider Services Departments are available to provide PCPs with orientation regarding CenCal Health's quality measures, strategies to maximize PCP data reporting, and sharing of best practices to help PCPs maximize service utilization consistent with prevailing evidence-based treatment and preventive health guidelines. PCPs can contact CenCal Health using the contact information listed below.

- Population Health Email: populationhealth@cencalhealth.org
- Provider Services Email: providerservices@cencalhealth.org

More information can also be found here:

<https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/>

L5: Performance Monitoring

To continually evaluate and improve the quality of care provided to CenCal Health's members, CenCal Health consistently monitors aspects of care prioritized by the Centers for Medicare & Medicaid Services (CMS). CenCal Health shares CMS' objective to collect, report, and use a standardized set of measures to drive improvement in Medicaid quality of care. The Healthcare Effectiveness Data & Information Set or "HEDIS" is one of the primary tools endorsed by the CMS and used by CenCal Health to measure the quality of healthcare provided to our members. Developed by the National Committee for Quality Assurance (NCQA), HEDIS provides a standardized methodology that is used nationally by health plans and regulators to evaluate important aspects of care.

CenCal Health begins its quality of care reviews every year in January, which includes several steps performed in strict accordance with HEDIS or other CMS quality measurement requirements. These steps include:

- Identification of members who qualify for inclusion in the measures. Members may be included based on their continuity of Medi-Cal eligibility, age, gender, medications, or diagnosis.
- Selection of a statistically significant sample of qualifying members for some measures. Sampling is not an option for many measures.
- Identification of members who have proof of evidence-based, clinically-recommended services, through claims and/or other data sources. These sources may include the California Immunization Registry (CAIR), information supplied by the California Department of Health Care Services (DHCS) and the California Department of Public Health, and clinical results submitted by many of CenCal Health's largest laboratories.
- Any member who does not have proof of services rendered will require medical record review at one or more provider offices, if supplemental medical record data collection is an option. Annually, CenCal Health's medical record reviews are completed from February through May. Every effort is made to accomplish this task in the least intrusive manner possible.

- Reporting of quality of care findings for the Santa Barbara Medi-Cal and San Luis Obispo Medi-Cal programs is submitted in June each year to the DHCS, and the National Committee for Quality Assurance (NCQA).

Remote medical record review via secure connection to providers Electronic Medical Record (EMR) systems is CenCal Health's preferred method to collect information from medical record sources. Alternatively, CenCal Health may accept additional data sources that reduce the burden to providers to

accommodate medical record review, including EMR data submissions. If you have questions about either of these options to provide medical record documentation, please contact CenCal Health's Quality Measurement Department at (805) 562-1609.

Because of the excellent healthcare afforded to our members by CenCal Health's providers, and consistently exceptional quality of care results, CenCal Health has been recognized as a leading managed care organization in California.

L6: Performance Improvement Projects (PIPs)

PIPs are rapid cycle quality improvement projects used to improve healthcare outcomes through process improvements over an 18-month period. These projects are required by the Department of Healthcare Services and must be reported to their designated External Quality Review Organization (EQRO). Performance improvement projects must be designed to achieve significant improvement in clinical or non-clinical areas of care expected to have a favorable effect on health outcomes and member satisfaction.

L7: Initial Health Assessments

Primary Care Providers (PCPs) are required to perform an Initial Health Assessment (IHA) for each newly assigned member within 120 days of assignment. CenCal Health informs new members that an IHA is a covered benefit and instructs them to call their PCP for an appointment to assure their health care risks and needs are assessed and met timely.

The PCP's obligation is to schedule and provide an IHA within 120 calendar days from the date of program eligibility, unless the PCP determines that the

member's medical record contains complete and current information to allow for assessment of the member's health status and health risk.

Program Components: The following IHA components must be documented in the PCP medical record:

- A comprehensive history of present illness including past and social history as well as a review of organ systems
- Comprehensive physical and mental status examination
- Perinatal Services (when applicable)
- Oral health assessment and dental screening and referral for children

- Assessment for age specific preventive screenings or services
 - For example: sexually transmitted infections
- Identification of high-risk behaviors
 - For example: drugs, alcohol, tobacco use
- Health education and anticipatory guidance appropriate for age
- Diagnosis and plan for treatment of any disease
- Individual Health Education Behavioral Assessment (IHEBA) or “[Staying Healthy Assessment](#)” (SHA) questionnaire

As soon as possible and no later than 60 calendar days following the IHA and IHEBA/SHA, PCPs must make arrangements for necessary follow-up, diagnostic, and/or treatment services for risk factors or disease conditions discovered. This includes the provision of age and risk appropriate immunizations in accordance with the findings of the IHA. For pregnant, breastfeeding, or postpartum women, or a parent/guardian of a child under the age of five (5), documentation of a referral to the WIC program is a required component of the IHA.

Staying Health Assessment (SHA): Providers are required to review SHA questionnaire results with their patients at their IHA visit and subsequent well-visits. A signature demonstrates compliance with this requirement. If answers to questions are recorded directly in the patient’s electronic medical record, then all SHA components must be included. Members have the right to refuse to answer any or all questions in the SHA. PCPs must document the refusal.

To learn more about SHAs and download the age-specific forms you can go to: <https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx>

Data Sources: CenCal Health tracks and monitors IHA’s via claims data.

Reports: All provider notifications regarding members in need of an IHA is communicated through monthly reports that are updated on CenCal Health’s [Provider Portal](#) in the Coordination of Care Section – Assigned Members tab.

For additional training on the portal, please contact CenCal Health’s Webmaster via email at webmaster@cencalhealth.org.

Pay for Performance: While the IHA incentive has been retired as of May 2022, the CenCal Health’s new [Quality Care Incentive Program](#) encourages IHA visits by way of the well care visit measures.

Monitoring: To assure the completion and documentation of required components addressed during an IHA visit, CenCal Health performs an

annual medical record review audit. Findings are shared via IHA Provider Performance Reports and discussed with audited PCPs. The completion of IHA documentation including the use of the SHA is also monitored through the Facility Site Review process.

Member Outreach: The PCP must attempt to perform the IHA at subsequent member office visits, even if the 120-day period has lapsed. At least three (3) documented

attempts that demonstrate unsuccessful efforts to contact a member and schedule an IHA are considered evidence in meeting the IHA requirement.

Billing and Payment:

PCPs should use the following CPT codes when billing for IHAs:

- Members less than 18 years of age:
 - New Patient: 99381-99384
 - Established Patient: 99391-99394
- Members 18 years and older:
 - New Patient: 99385-99387
 - Established Patient: 99395-99397
- Members who are Pregnant:
 - Z1032, Z1034, Z1038, Z6500, 59400, 59510, 59610, 59618

URLs for above hyperlinks:

Staying Healthy Assessment

<https://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx>

Quality Care Incentive Program

<https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/>

L8: Mandated Reporting of Provider Preventable Conditions (PPC)

Provider Preventable Conditions (PPCs) consist of health care-acquired conditions (HCAC) when they occur in acute inpatient hospital settings only and other provider-preventable conditions (OPPC) when they occur in any healthcare settings. HCACs are the same as hospital-acquired conditions (HAC) for Medicare, except that Medi-Cal does not require providers to report deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age.

Requirement Timelines

In March 2013, CenCal Health providers were notified that the Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services (CMS) to require providers to report Provider Preventable Conditions (PPCs). Federal legislation prohibits CenCal Health from paying for the treatment of PPCs, and payment adjustment may be applied. PPCs are divided into two categories: Other Provider Preventable Conditions (OPPCs) in all healthcare settings and health care-acquired conditions (HCACs) in inpatient acute care hospital settings only.

On March 30, 2016, CMS issued new PPC reporting requirements in rulemaking CMS-2390-F, in which CMS further defines OPPC's as conditions that 1) are identified by the State plan; 2) are reasonably preventable through the application of procedures supported by evidence-based guidelines; 3) have a negative consequence for the beneficiary; 4) are auditable, and 5) include, at a minimum, the procedures referenced below.

OPPCs are also known as "never events" and Serious Reportable Events under Medicare. For Medi-Cal, OPPCs are defined as follows: Providers must report the following three OPPCs when these occur in any healthcare setting. "Invasive procedure" refers to a surgical procedure.

- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Providers must report the occurrence of PPCs that are associated with claims for Medi-Cal payment or with courses of treatment prescribed to a CenCal Health beneficiary for which payment would otherwise be available. Providers do not need to report PPCs that existed prior to the initiation of treatment of the beneficiary by the provider. Reporting is required to evaluate whether the occurrence extended care and determine whether CenCal Health can adjust any payment previously made. PPC reporting is mandated for Medi-Cal

beneficiaries eligible through the State Medi-Cal Program under Fee-For-Service, as well as for members of CenCal Health.

Inpatient acute care hospitals and facilities are required to report OPPCs and HCACs for any CenCal Health member. To report a PPC, providers must:

- Login to the [California Department of Health Care Services](#) website to submit information for each provider-preventable condition, and;
- Send CenCal Health a copy of the PPC Report, via fax to (805) 681-3075. Generating this form is described within DHCS's [Provider-Preventable Conditions](#) page; the online portal allows providers to print their PPC Report after they submit the PPC Report to DHCS via the portal.

Providers must submit the form within five (5) days of discovering the event.

Please note: reporting PPC to CenCal Health, or DHCS, for any Medi-Cal beneficiary does not preclude the provider from reporting adverse events and healthcare associated infections (HAIs) to the California Department of Public Health for the same member.

Claims submitted for treatment of PPCs should also be identified on the claim form. For OPPCs, a modifier is required to be reported whereas HCACs must utilize diagnosis codes, and in some cases procedure codes, to indicate any Corresponding Complication (CC) or Major Complication or Co-morbidity (MCC) related to the PPC.

For any questions regarding this federally mandated DHCS reporting, please contact the Provider Services Department at (805) 562-1676, or Providers may email questions about PPCs to PPCHCAC@dhcs.ca.gov.

Provider Preventable Conditions

Other Provider Preventable Conditions (OPPC) – reportable in all healthcare settings; claims for OPPC must include the PPC modifiers as indicated in parentheses ().

Health Care-Acquired Conditions (HCAC) – reportable in inpatient acute care hospital settings only; claims for HCACs must include the Corresponding Complication (CC) or Co-Morbidity/Major Complication (MCC) ICD-10 diagnosis codes and/or procedure code; please refer to the list of HCAC claim coding on our website in the Hospital Provider Obligations section of the Provider Manual under [Section D, D3](#):

Providers need to report HCACs only when they occur in inpatient acute care hospitals.

HCACs:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
-

- Deep vein thrombosis/pulmonary embolism (excluding pregnant women and children under 21 years of age)
 - Total Knee Replacement
 - Hip Replacement
- Falls/trauma that result in the following:
 - Fracture
 - Dislocation
 - Intracranial injury
 - Crushing injury
 - Burn
 - Other injuries
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
 - Diabetic ketoacidosis
 - Nonketotic hyperosmolar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity

- Stage III or IV pressure ulcers
- Surgical site infection
 - Mediastinitis following coronary artery bypass graft (CABG)
 - Surgical site infections following:
 - Bariatric surgery
 - Laparoscopic gastric bypass
 - Gastroenterostomy
 - Laparoscopic gastric restrictive surgery

- Orthopedic procedures for spine, neck, shoulder, and elbow
- Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection

Claim Reporting

HCAC must utilize diagnosis codes to indicate any Corresponding Complication (CC) or co-morbidity or major complication (MCC) related to the PPC. Federal legislation prohibits Medi-Cal payment for the treatment of PPC, and payment adjustment may be applied.

Please reference the [CMS.gov](https://www.cms.gov) website for a list of required diagnosis codes, and in some cases procedure codes that can be reported on a claim related to HCAC.

L9: Hospital Readmission Program

CenCal Health's Hospital Readmission Program is a PCP pay-for-performance program for members recently discharged from a hospital inpatient stay.

The primary goal of this program is to reduce 30-day inpatient hospital readmissions for CenCal Health members by ensuring timely completion of a post-discharge visit after an acute inpatient hospital stay.

Payment

A \$100 incentive is paid to PCPs per qualified follow-up visit rendered within five business days after a hospital discharge.

Follow-Up Visits can be rendered and are payable to a PCP for his/her assigned members as well as for members that are not assigned to that PCP's practice. For those members who are not assigned, Referral Authorization Forms (RAFs) are not required for follow-up visits.

Appeal Process

CenCal Health acknowledges that the data received from acute care hospitals is not perfect. If any member is admitted as an inpatient and discharged from an acute hospital, but not reported to CenCal Health, providers may appeal to have completed Follow-Up Visit(s) considered for payment by contacting the Provider Services Department at (805) 562-1676. Provider appeals must be received for consideration within 180 days from the date of service of the Follow-Up Visit.

L10: Value-Based Payment Program

The Department of Health Care Services (DHCS) established a Value Based Payments Program (VBP) utilizing funding from The California Healthcare, Research & Prevention Tobacco Tax Act of 2016 (Proposition 56). CenCal Health administers the program by providing supplemental payments to providers that meet specific performance measures aimed at improving care for some of the most vulnerable members of the communities CenCal Health serves. The VBP Program is subject to DHCS approved funding.

In total, there are seventeen (17) performance measures that encompass four (4) domains (Maternity Care, Pediatric Preventive Care, Chronic Disease

Management, and Behavioral Health Integration). Measures of immunization timeliness are computed with supplemental data from the California Immunization Registry (CAIR).

In consideration for health disparities, payments are increased for members diagnosed with substance use disorder, serious mental illness (Schizophrenia, Bipolar Disorder, Other Bipolar Disorder, and Major Depression), or homeless or inadequate housing.

VBP Measures

1. Prenatal Pertussis (Whooping Cough) Vaccine
2. Prenatal Care Visit
3. Postpartum Care Visits
4. Postpartum Birth Control
5. Well-Child Visits in First 15 Months of Life
6. Well Child Visit in 3rd – 6th Years of Life
7. All Childhood Vaccines for Two Year Olds
8. Blood Lead Screening
9. Dental Fluoride Varnish
10. Controlling High Blood Pressure
11. Diabetes Care – Hemoglobin A1c Testing
12. Control of Persistent Asthma
13. Tobacco Use Screening
14. Adult Influenza (Flu) Vaccine
15. Screening for Clinical Depression
16. Management of Depression Medication
17. Screening for Unhealthy Alcohol Use

VBP Payments

In accordance with DHCS requirements, VBP payments must be made to the rendering provider. Since CenCal Health's contracts are sometimes with a group, payments are made to the contracted entity. However, CenCal Health requires that the incentive payments be distributed to each rendering provider.

VBP Exclusions

Claims for VBP program services must be received from contracted providers no more than one year from the date of service. Members with Medicare Part B, or encounters occurring at Federally Qualified Health Centers (FQHCs), Rural

Health Clinics, American Indian Health Clinics, or Cost Based Reimbursement Clinics are excluded from program eligibility.

Section M: Member Services

M1: Member Rights and Responsibilities

CenCal Health members have certain rights and responsibilities. The [Member Handbook](#) will explain those rights and responsibilities. Please visit the CenCal Health website to download the [Member Handbook](#).

URLs for above hyperlinks:

Member Handbook

<https://www.cencalhealth.org/members/member-handbook/>

M2: Nondiscrimination Notice

Discrimination is against the law. CenCal Health follows State and Federal civil rights laws. CenCal Health does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group, identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. To learn more about Notice of Non-Discrimination, please visit the CenCal Health website and download the [Member Handbook](#).

URLs for above hyperlinks:

CenCal Health Member Handbook

<https://www.cencalhealth.org/members/member-handbook/>

M3: Mid-Month Process

Mid-Month changes are made to facilitate continuity of care and prevent access problems. Requests for Mid-Months can be made by either the member or the provider. If a provider calls CenCal Health to request a Mid-Month, we will need to speak with the member before the request can be approved.

The following are the guidelines regarding Mid-Months:

- The cut-off date (last date) to request a Mid-Month will vary from month to month, but it's usually around the 13th or 14th of the month. After this date, we will no longer be able to change a member's PCP retro-actively to the 1st of the current month.
- **All Mid-Month changes are retroactive to the first of the current month** regardless of the day in which the Mid-Month was processed and/or approved. By approving a Mid-Month, the provider agrees to case manage a member for all medical care received retroactively to the first day of the month.
- CenCal Health's eligibility system and website eligibility system will be updated immediately to reflect Mid-Month changes. Providers are urged to make notations to their capitation monthly report indicating a Mid-month addition to their list as well as a Mid-Month deletion. **Please remember that a provider can treat a member immediately, after the Mid-Month has been approved.**

- A Mid-Month Capitation Report is generated after the cut-off date and mailed out to the provider. It will list all members that were retroactively added back to the first of the current month.

The Member Services staff uses the following Mid-Month criteria:

- The member has an established relationship with the PCP they are requesting
- The member has an appointment in the current month
- The member needs ongoing or urgent care.
- The Member needs a Child Health and Disability Prevention Program “CHDP” exam and/or immunizations
- The member has not been seen in the current month by the PCP that they are currently assigned to

If for whatever reason a Mid-Month does not process correctly, CenCal Health has an administrative referral process by which a provider’s claim can be processed. Therefore, if the provider approves the Mid-Month and determines that the member does not appear on their capitation report, the provider can request an administrative referral from CenCal Health which will ensure that the provider’s claim is processed and will not require a referral from the original PCP. Please contact Provider Services if you need assistance with an administrative referral.

M4: Assistance with Member No-Shows

CenCal Health recognizes that members missing their appointments can create scheduling issues for providers. CenCal Health’s Member Services Department offers support and assistance with member “no-shows” through member coaching and education, important tools when helping members understand the importance of keeping scheduled appointments and the consequences should they miss them.

Providers can request the following assistance by contacting the Member Services Department:

- Member Services contacts the member and provides “**direct one on one**” education regarding missed appointments. This should occur as soon as the provider identifies that the member has missed an appointment without cancelling, thereby addressing the issue before it becomes a problem.
- If transportation has been identified as a barrier to keeping appointments, Member Services can provide members with information regarding alternate transportation and offer referrals to community resources.
- Member Services will strive to identify and address any other issues that may be leading to the member missing appointments.

Articles regarding the importance of keeping scheduled appointments regularly appear in the CenCal Health Member Newsletter.

Providers can call the Member Services Department for assistance, Monday through Friday, 8AM to 5PM at (877) 814-1861 or fax a list of members to (805) 692-1684. Providers will be notified, once education has been provided.

Section N: Language Assistance Program

N1: Obtaining Access to Cultural and Linguistic Services

State and Federal regulations require CenCal Health to make interpreter and translation services available for limited English proficient members. Limited English proficient (LEP) members include those who have a limited ability to read, speak, write or understand English. CenCal Health is also required to facilitate, promote and provide training in cultural competency for its staff, as well as for health network staff and CenCal Health providers. CenCal Health's Cultural and Linguistic Services program provides and facilitates interpreter and translation services.

The Department of Health Care Services (DHCS) periodically audits CenCal Health's Language Assistance Program which includes interpreter and translation services, as well as on our provider trainings. DHCS auditors may select individual provider offices to review as a part of this audit, to verify whether LEP members are informed of the availability of language assistance and have been offered interpreter services. CenCal Health will contact, in advance, provider offices selected by the DHCS to participate in its cultural and linguistic services audit when possible.

N2: Accessing Interpreter Services

Providers may request interpreter services for their CenCal Health patients with limited English proficiency. We encourage providers to use CenCal Health's 24/7 telephonic interpreter Service for most routine appointments. Video Remote Interpreting (VRI) for face-to-face interpreter needs for ASL, Spanish and 20 other languages are also now available for specialty appointments through Certified Language International by using their assigned password. Providers may also request face-to-face interpreter services (Spanish) if criteria for these services are met for a network interpreter to be sent to the appointment. For help in identifying your patient's preferred language, see the Provider section of the CenCal Health website.

How to Request Interpreter Services

- Verify the member's eligibility and identify if the member is enrolled with CenCal Health. The member **MUST** be a member of CenCal Health to use CenCal Health interpreting services, and you may be responsible for payment if determined to be misusing services for non-CenCal Health members.
 - Telephonic interpreter service is to be used for all routine services that do not meet the criteria as noted in Section N, N7 Language Access Program. This service is available 24 hours a day, seven days a week.
 - Video Remote Interpreting (VRI) service is to be used for ASL members and 21 other languages available on demand. Please note that only ASL and Spanish is available 24/7. For cost-effectiveness, CenCal Health asks providers to utilize CLI's voice-only interpreting services whenever possible, and use VRI for complex appointments. For a list of all languages go to cencalhealth.org/providers/cultural-linguistic-resources/
 - Face-to-face (in-person) Spanish and ASL interpreter services, are available based upon the noted criteria in Section N7. This service is available for scheduled medical appointments in an ambulatory setting, and requires at least five working days' advance notice.

- American Sign Language is available on-demand through VRI, however, if it requires a face-to-face interpreter in-person, please request at least 5 working days in advance notice.
- Please have the following information ready for Face-to-Face scheduling at the time of the request:
 - Member's name
 - Member's CIN or ID#
 - Member's gender and age
 - Date and Time of appointment
 - Type of visit and approximate duration within the noted criteria (does not apply to ASL)
 - Name of doctor/facility
 - Address and phone number of appointment/location
- If the member is eligible with CenCal Health, please contact CenCal Health's Member Services Department by calling **(877) 814-1861**. Prior authorization is required if criteria is met.

URLs for above hyperlinks:

Language List and Hours of operation

<https://www.cencalhealth.org/providers/cultural-linguistic-resources/>

N3: Documenting Member Refusal of Interpreter Services

CenCal Health ensures that qualified interpreters are professionally trained, culturally competent and well-versed in medical terminology and managed care concepts. Because of these requirements, it is important that provider offices document when members refuse to use the telephonic or face-to-face qualified interpreter services. We recommend documenting the refusal of any of the interpreter services available to providers (telephonic, VRI, or face-to-face) in the member's record. Documenting refusals can protect the provider and the provider's practice and it ensures consistency when medical records are monitored through site reviews or audits to ensure adequacy of CenCal Health's Language Assistance program.

N4: Tips for Documenting Telephonic, Video or Face-to-Face Interpreter Services

- CenCal Health recommends documenting whenever telephonic, VRI or face-to-face, including ASL interpreter services are used, in the member's medical record.
- If the member was offered interpreter services and they refused, it is important to note that refusal in the member record for that visit.
- Using a family member or friend to interpret should be discouraged. However, if the member insists on using a family member or friend, it is extremely important to document this in the medical record. Minors should never be used to interpret. Consider offering a telephonic or video interpreter in addition to the family member/friend to ensure accuracy of interpretation when this occurs.
- For all limited English proficient members, it is a best practice to document the member's preferred language in paper and or electronic medical records in the manner that best fits your practice.

Source: Industry Collaboration Effort (ICE) Tips for Communicating Across Language Barriers; www.iceforhealth.org/.

N5: Working with Interpreters for Face-to-Face, Telephonic, and Video Services

Certified Languages International (<https://certifiedlanguages.com>) hires the very best interpreters available from a nationwide database.

Our face-to-face interpreters for Spanish and ASL needs are independent contractors who we have assessed and tested to assure that they have the highest level of accuracy and professionalism.

However, language interpretation is a three-way conversation between yourself, your patient and the interpreter. Please discuss concerns or issues together to improve all parties' experience, and report any feedback you would like CenCal Health to know to CenCal Health's Cultural & Language Program & Resource Coordinator.

N6: Working with Limited English Proficient (LEP) Members

It is important that providers know how to identify, offer and access interpreter services for LEP members. Below are some recommended tips on how to work with limited English proficient members.

- **Who are considered LEP members?** Individuals who do not identify English as their preferred language and who have a limited ability to read, speak, write or understand English, may be considered LEP.
- **How to identify LEP members over the phone.** An LEP member may exhibit the following characteristics:
 - Is quiet or does not respond to questions.
 - Responds with a simple "yes" or "no," or gives inappropriate or inconsistent answers to your questions.
 - May have trouble communicating in English or you may have a very difficult time understanding what he or she is trying to communicate.
 - Identifies as LEP by requesting language assistance.
- **How to offer interpreter services to an LEP member when a member does not speak English and you are unable to discern the language.** If you are unable to identify the language spoken by the LEP member, you should request telephonic or video interpreter services through Certified Languages International (CLI) to identify the language needed.
- **How to best communicate with an LEP member who speaks some English but with whom you are having difficulty communicating.** Speak slowly and clearly with the member. Do not speak loudly or shout. Use simple words and short sentences.
- **How to offer interpreter services to the member.** Here are a couple of recommended ways to offer interpreter services:
 - "I think I am having trouble explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you prefer to speak?"

- “I am going to connect us with an interpreter. Which language do you speak?” Call Certified Languages International for assistance.
- If using Video Remote Interpreting (VRI), the member can point to the language they speak.
- Best practice to capture language preference. For LEP members, it is a best practice to capture the member’s preferred language and record it in the plan or provider’s member data system. You may want to consider asking the following question:
 - “In order for (provider’s name) to be able to communicate most effectively with you, may I ask what is your preferred spoken and written language?”

N7: Language Access Program

CenCal Health offers language line assistance and interpreter services for qualifying visits, to assist with communication during medical services for our membership only.

Telephonic and video interpreting services are simple, available 24 hours a day, and free of cost to providers and members. These services can assist with communication between providers and members who do not speak the same language also known as Limited English Proficient (LEP).

To access language services, complete the steps below:

Telephonic Interpreter Services

1. Dial the toll-free number: **(800) 225-5254**
2. Provide operator customer code: **48CEN**
3. Indicate to operator that you are calling from **CenCal Health – Providers**
4. Request Language needed
5. Provide your name and phone number, provider’s last name, NPI #, CenCal Health member ID and patient name

Video Remote Interpreting (VRI)

1. Go to the VRI web address: **cencalhp.cli-video.com**
2. Enter the VRI access code: **48cencalhp**
3. Enter required information:
 - Caller’s full name
 - Phone number
 - Doctor’s last name
 - NPI #
 - Member ID #
 - Patients last name
4. Select the appropriate language to connect to an interpreter via video
VRI [User](#) Guide for VRI

Face-to-Face Interpreters

Face-To-Face interpreter services may be authorized by CenCal Health for members requiring the following CenCal Health-covered services:

- Services for members who are deaf and hard of hearing (American Sign Language (ASL))
- Abuse or sexual assault issues



- End of life issues/ Hospice
- Complex procedures or courses of therapy
- First Physical Therapy appointment and re-check appointment
- First Oncology Appointment
- First Orthopedic Appointments

Prior authorization via the Member Services Line at (877) 814-1861 is required for face-to-face interpreter services requests for those Spanish-speaking members who meet the criteria noted above. CenCal Health encourages providers to coordinate face-to-face interpreter services at least 5 business days prior to appointment. Upon authorization of service, the Cultural and Language Program & Resource Coordinator will schedule a qualified interpreter for the requested date of service. For more information regarding [Language Assistance](#), please visit CenCal Health's website.

URLs for above hyperlinks:

User Guider for VRI

<https://www.cencalhealth.org/~media/files/pdfs/providers/for-providers/cultural-and-linguistic/clivriuserguidewithbluestreatmtechsupport202003.pdf?la=en>

VRI Frequently Asked Questioning

<https://www.cencalhealth.org/~media/files/pdfs/providers/for-providers/cultural-and-linguistic/clivrifaq202003.pdf?la=en>

VRI Minimum Requirements

<https://www.cencalhealth.org/~media/files/pdfs/providers/for-providers/cultural-and-linguistic/clvrminimumrequirements202003.pdf?la=en>

N8: Language Assistance

ATTENTION: If you speak another language, [language assistance services](#), free of charge, are available to you. Call CenCal Health Member Services at 1-877-814-1861, or if you cannot hear or speak well (TTY/TDD: 1-833-556-2560 or CA Relay at 711).

URLs for above hyperlinks:

CenCal Health Language Assistance Taglines

<https://www.cencalhealth.org/~media/files/pdfs/members/mu-0004142-eng3-0321-m-ms-hiyl-0621-es.pdf>



Interpretation Service Available

English Translation:

Point to your language. An interpreter will be called.

The interpreter is provided at no cost to you.

Arabic عربي أشر إلى لغتك. وسوف يتم جلب مترجم فوري لك. سيتم تأمين المترجم المذأور مجاناً.	Korean 한국어 귀하께서 사용하는 언어를 지적하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.
Armenian Հայերեն Յոյց տուէք ո՞ր մէկ լեզուն կը խօսիք՝ Թարգմանիչ մը կանչել կը տանք. Թարգմանիչը կը տրամադրուի անվճար.	Laotian ພາສາລາວ ຊື້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້. ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້. ທ່ານບໍ່ຕ້ອງເສຍເງິນຄ່າແປໃຫ້ແກ່ນາຍແປພາສາ.
Cantonese 廣東話 請指認您的語言， 以便為您提供免費的傳譯服務。	Mandarin 國語 請指認您的語言， 以便為您提供免費的口譯服務。
French Français Pointez vers votre langue et on appellera un interprète qui vous sera fourni gratuitement.	Polish Polski Proszę wskazać swój język i wezwiemy tłumacza. Tłumacza zapewnimy bezpłatnie.
German Deutsch Zeigen Sie auf Ihre Sprache. Ein Dolmetscher wird gerufen. Der Dolmetscher ist für Sie kostenlos.	Portuguese Português Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.
Hindi हिंदी अपनी भाषा पर इंगित करें और एक दुभाषिया बुलाया जाएगा। दुभाषिये का प्रबन्ध आप पर बिना किसी खर्च के किया जाता है।	Russian Русский Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.
Hmong Hmoob Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.	Spanish Español Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.
Italian Italiano Puntare sulla propria lingua. Un interprete sarà chiamato. Il servizio è gratuito.	Tagalog Tagalog Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.
Japanese 日本語 あなたの話す言語を指して下さい。 無料で通訳を提供します。	Thai ไทย ช่วยชี้ที่ภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน การใช้ล่ามไม่ต้องเสียค่าใช้จ่าย
Khmer (Cambodian) ខ្មែរ (កម្ពុជា) សូមចង្អុលភាសាអ្នក។ យើងនឹងហៅអ្នកបកប្រែភាសាមកជូន។ អ្នកបកប្រែភាសានឹងជួយអ្នកដោយមិនគិតថ្លៃ។	Vietnamese Tiếng Việt Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên.

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CLI INSTRUCTION CARD: OVER-THE-PHONE INTERPRETING SERVICES

NEED AN INTERPRETER?

1. **DIAL 1-800-CALL-CLI (1-800-225-5254)**
2. When the operator answers, tell them:
 - a. Your customer code is **48CEN**
 - b. You are calling from **CenCal Health - Providers**
 - c. The language you need
 - d. Your **phone #, doctor's last name, NPI #, CenCal health member ID #** and **patient name**
 - e. If you need a third-party dial-out
3. The operator will connect you promptly



CERTIFIED LANGUAGES
INTERNATIONAL

200+ Languages
24/7/365 Service
Direct Dial: 503-484-2425



Recommendations for Using an Over-the-Phone Interpreter

For Outbound Calls:

- If you need to reach a Limited English Proficient (LEP) at home or need a third-party dial-out, please first inform the CLI rep before the interpreter is connected.
- Once the interpreter is connected, you can tell the interpreter who to ask for (the LEP's name).
- At this time, you can also tell the interpreter how to proceed if the call goes to voicemail and what message to leave, if desired.

For Inbound Calls:

- Explain to the LEP that all info is confidential and encourage questions.
- Speak clearly.
- Smile and be kind; this helps the LEP feel more comfortable.
- If face-to-face and multiple people are in the room, speak one at a time.
- Speak freely; all CLI interpreters are sworn to confidentiality, neutrality, and the Interpreter Code of Professional Ethics.
- Encourage the interpreter to clarify terms with you if necessary.

Thank you for using CLI's video remote interpreting (VRI) solution. Here are a few simple steps to connect with a video interpreter.

Your VRI web address:

.cli-video.com

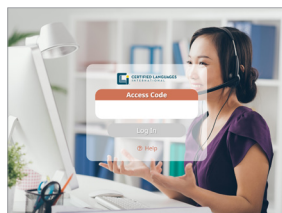
Your VRI access code:

STEP
1



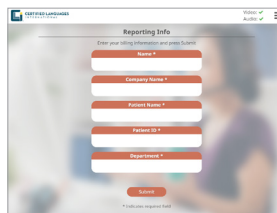
Make sure you are connected to the internet. Navigate to your VRI web address.

STEP
2



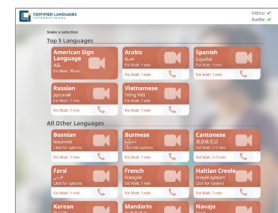
Enter your access code to sign in.

STEP
3



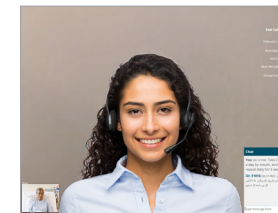
Enter the required information and press the "Submit" button.

STEP
4



Select the language you need to connect to an interpreter via video or audio.

STEP
5



Upon connection, an interpreter will appear on the video screen or connect via audio. Your session will now begin.

Tips for a Successful VRI Session

- Remember: Interpreters must interpret any and all words they hear.
- Patients and staff should not hold the video device.
- Speak directly to the patient – not to the interpreter.
- Use the chat box for written instructions.
- Focus the camera on the patient only. Position the camera angle in a way that maintains privacy for the patient at all times.
- When extra privacy is needed, select "Camera Off" under the video camera icon.
- In order to ensure a quality visual connection, make sure the patient is not backlit by a window or any other light source.
- Use the self-view screen in the lower left corner to ensure the interpreter can see the patient clearly; ask the interpreter to confirm that their visual connection is clear.
- After the interpreting session ends, rate your call to submit feedback on quality.

Troubleshooting Assistance

Internal IT Support:

Tips: The VRI web platform is optimized for Chrome and Firefox (on PC devices) and for Safari (on Apple/iOS devices).

Please refer to CLI's VRI FAQs for more troubleshooting assistance.

Language List: Video Remote Interpreting (VRI)



Speak any language in seconds

Availability (Pacific Standard Time)

American Sign Language (ASL)	24/7/365
Spanish	24/7/365
Arabic	Monday – Friday, 5 a.m. – 7 p.m.
Bosnian	Monday – Friday, 5 a.m. – 7 p.m.
Burmese	Monday – Friday, 5 a.m. – 7 p.m.
Cantonese	Monday – Friday, 5 a.m. – 7 p.m.
Farsi	Monday – Friday, 5 a.m. – 7 p.m.
French	Monday – Friday, 5 a.m. – 7 p.m.
Haitian Creole	Monday – Friday, 5 a.m. – 7 p.m.
Hmong	Monday – Friday, 5 a.m. – 7 p.m.
Karen	Monday – Friday, 5 a.m. – 7 p.m.
Korean	Monday – Friday, 5 a.m. – 7 p.m.
Mandarin	Monday – Friday, 5 a.m. – 7 p.m.
Nepali	Monday – Friday, 5 a.m. – 7 p.m.
Polish	Monday – Friday, 5 a.m. – 7 p.m.
Portuguese (Brazil)	Monday – Friday, 5 a.m. – 7 p.m.
Punjabi	Monday – Friday, 5 a.m. – 7 p.m.
Romanian	Monday – Friday, 5 a.m. – 7 p.m.
Russian	Monday – Friday, 5 a.m. – 7 p.m.
Somali	Monday – Friday, 5 a.m. – 7 p.m.
Swahili	Monday – Friday, 5 a.m. – 7 p.m.
Vietnamese	Monday – Friday, 5 a.m. – 7 p.m.

Section O: Provider Complaints and Grievances

O1: Provider Complaints and Grievances

CenCal Health has developed a process to address provider complaints and grievances efficiently and fairly. This policy provides an avenue for contracted and non-contracted providers to bring concerns or opportunities for improvement to CenCal Health's attention, and thus drive CenCal Health operations and direction, as appropriate.

Definitions

Complaint: A complaint is a request for assistance or an expression of dissatisfaction related to non-clinical member issues, aspects of CenCal Health's administration of its programs, or other issues.

Grievance: A formal written expression of dissatisfaction by a provider with any aspect of CenCal Health's operations, with the exception of CenCal Health decisions regarding claims or service authorizations, regardless of whether any remedial action is requested or can be taken.

Procedure

1. Receipt of Provider Claims Inquiries, Disputes or Appeals; and Authorization Inquiries or Appeals

If a provider contacts Provider Services with issues outside their purview (claims inquiries or appeals, authorization inquiries or appeals, clinical or quality of care concerns), the Provider Services Customer Representative will "warm transfer" the caller to the appropriate department. The appropriate department, to address the grievance, unless otherwise requested, shall review and respond as appropriate.

A. Receipt and Resolution of a Provider Complaint or Grievance:

- I. The Provider Services Department is charged with the resolution of provider complaints and grievances. The complaint may be related to: non-clinical member issues, aspects of CenCal Health's administration of its programs, or other issues. The provider may file a complaint with the Provider Services Department via a telephone call, fax, e-mail or handwritten letter.
- II. If a complaint has no clinical or quality of care aspect, the PSR determines whether the provider needs routine assistance or would like to file a formal grievance. Formal grievances must be submitted in writing, preferably on the provider's letterhead.
- III. Informal complaints and requests for routine assistance are addressed by the PSR, with assistance from other staff as needed. Formal written acknowledgements or resolutions are generally not necessary for these matters.
- IV. If the provider submits a written formal grievance, the PSR will notify the Provider Services Quality Liaison, who will send a receipt acknowledgment letter within five business days.
- V. The PSR will collaborate with other staff as needed to investigate and resolve the provider's grievance. Following resolution of the complaint, the PSR will document the case and the outcome, and the Quality

Liaison will send a resolution letter. All grievances are resolved within 45 business days.

2. Disclosure to Providers and Members

Providers are informed of their right to file complaints and grievances, and the availability of assistance in the filing process, in a variety of ways. This may include, but is not limited to: through their provider contract agreements or amendments, CenCal Health's website, Provider Bulletins, and in provider materials and manuals issued by CenCal Health and updated periodically.

CenCal Health's grievance system is in addition to any other dispute resolution procedures available to the provider. The provider's failure to use these procedures does not preclude the provider's use of any other remedy provided by law.

CenCal Health's Chief Operating Officer and Legal Counsel should be notified immediately when a provider's legal representative contacts CenCal Health regarding the pursuit of legal action to resolve a complaint or appeal.

CenCal Health will not discriminate or retaliate in any manner, including but not limited to the cancellation of the provider's contract, against a provider who files a grievance.

Grievances shall be received, handled, and resolved without charge to the provider. However, CenCal Health shall have no obligation to reimburse a provider for any costs incurred in connection with filing a complaint or grievance.

3. Confidentiality and Privacy Regarding Record Retention

All provider complaints and appeals shall be placed in designated files and maintained by the Provider Services Quality Liaison for at least ten (10) years after the resolution; the files of the previous two (2) years shall be in an easily accessible place at CenCal Health's offices.

4. Monitoring of the Process

Reports: The Provider Services Quality Liaison will prepare a quarterly summary of provider complaints and grievances to be presented to CenCal Health's Network Management Committee and Board of Directors. The summary shall summarize the number and type of provider complaints, grievances and appeals.

O2: Member Grievance and Appeal Process

Providers can offer to help members file a grievance or an appeal. They can also file appeals on their behalf with their patient's approval. The following information explains the process for member grievance and appeal filing.

CenCal Health members have the right to file a grievance about their experiences with the Plan or its providers. While many providers have internal policies for resolving patient complaints/grievances, CenCal Health provides a Grievance and Appeal System for our members to express their dissatisfaction or to appeal a decision that they do not agree with. We do not delegate this activity to our provider network.

For appeals, members have 60 calendar days from the date of the Notice of Action Letter (NOA) or decision to submit an appeal. For Grievances, there is no longer a time limit to file. An appeal or grievance request can be made by the member, the authorized representative or by a provider on behalf of the member.

If a member asks to file a grievance or an appeal with the provider, the provider's office staff should give him/her the appropriate forms and instructions. Forms are available in English and Spanish, and copies of these forms should be made readily available for CenCal Health members in your office, and are available at the following links:

Appeal Form: [English](#) or [Spanish](#)

Grievance Form: [English](#) or [Spanish](#)

HOW TO ASSIST MEMBERS IN FILING GRIEVANCES OR APPEALS

A grievance or an appeal can be filed by members or on behalf of members by any of the following methods:

- By calling CenCal Health's Member Service Department at our toll free number 1-877-814-1861.
- In person, by visiting CenCal Health.
- By completing a Grievance/Appeal Form and/or submitting in writing to:
CenCal Health
Attn: Grievance & Appeals
4050 Calle Real
Santa Barbara, CA 93110
- Via website at this link: <https://www.cencalhealth.org/members/file-complaint/>

Standard and Expedited Review Processed

Standard - In most circumstances, grievance or appeal requests will be processed through the Standard Grievance/Appeal Review Process. This is a 30-day max timeframe for review. The timeframe may however be extended an additional 14 calendar days (for appeals only), if there is a need for additional information to make a decision and/or if the delayed decision is in the best interest to the member.

The standard process include a written resolution of the grievance or appeal within 30 calendar days of filing.

Expedited - An expedited review of an appeal can be requested in certain cases. This is a 72-hour allowed timeframe for review. This process supports resolution of the appeal within 72 hours when a delay in a decision using the 30-day standard process may seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum function. A CenCal Health physician reviewer will determine if the appeal request meets expedited criteria for processing.

If the expedited process is granted, a physician reviewer who was not involved in the original decision will complete the review and resolution of that appeal is provided to the requestor within the 72 hours of filing. An attempt will be made to notify the member verbally of the decision within the 72 hours and is also followed by written notification.

If the CenCal Health Physician Reviewer determines the appeal does not meet expedited criteria for processing, the process will revert to the standard appeal process for resolution.

PROVIDER RESPONSIBILITIES

Providers must cooperate with CenCal Health in identifying, processing and resolving all member grievances and appeals.

Cooperation in this process includes, but is not limited to:

- Speaking with CenCal Health Grievance & Appeals Coordinators to assist with resolving the grievance or appeal in a reasonable manner.
- Having designated staff available for grievance and appeal investigation.
- Completing a provider response in writing, if requested. Providers may choose to respond in writing at any time as well and often provide written documentation of their requests when filing on a member's behalf.
- Responding to all information/documentation requests made by CenCal Health related to the grievance or appeal: medical record requests, provider's response to the complaint, scheduling documentation/ phone logs and/or other supporting documentation needed for CenCal Health's review.
- Responding to requests timely (within 7 business days at a maximum).

If providers would like to file an appeal on behalf of a member, providers must now obtain written consent from members to do so. This signed consent should be submitted with your appeal request. CenCal Health is able to initiate an appeal filed by a provider for a member, with at the least, verbal authorization from the member. DHCS requires CenCal Health to request written consent even if verbal authorization is obtained, so it is best to obtain written authorization for submission when filing the appeal request.

CenCal Health's Grievance & Appeal Team is available to answer any questions you may have about this process at any time. Please contact us through the Member Services Call Center at 1-877-814-1861 and ask to speak with a Grievance Coordinator.

Section P: Health Education and Information

P1: Health Education Services

CenCal Health members are eligible to receive health education services at no charge as part of preventive and primary healthcare visits. Health risk behaviors, health practices, and health education needs related to health conditions should be identified, and educational interventions, including counseling and referral for health education services, should be conducted and documented in the member's Medical Record.

A variety of educational strategies, methods, and materials should be used that are appropriate for the CenCal Health member population and that are effective in achieving behavioral change for improved health.

Resources and Support for Providers

CenCal Health can assist you with developing and delivering culturally and linguistically appropriate health education interventions for your patients.

Training is available for the following areas:

- Techniques to enhance effectiveness of provider/patient interaction
- Health plan and community health education resources available and procedures for referring individual Members to appropriate services
- Health education requirement standards, guidelines and monitoring
- Population Needs Assessment findings.

For information to support health education services in your practice, contact the Senior Health Promotion Educator at healthed@cencalhealth.org or (800) 421-2560 ext. 1662.

Resources for CenCal Health Members

CenCal Health members can also be referred to the Health Education Request Line at (800) 421-2560 ext. 3126 to request specific materials or other health education needs from CenCal Health.

CenCal Health's library of [patient education](#) materials are available for download at no cost, in English and Spanish.

URLs for above hyperlinks:

CenCal Health Health and Wellness

<https://www.cencalhealth.org/health-and-wellness/>

Section Q: Fraud Waste and Abuse (FWA) & Protected Health Information (PHI)

Q1 Overview of Fraud, Waste and Abuse

CenCal Health maintains an Anti-Fraud, Waste, and Abuse (FWA) Plan that demonstrates its commitment to prevent, detect and correct incidents of FWA within the network. CenCal Health maintains a FWA hotline for anonymous reporting and a Special Investigations Unit (SIU) that investigates all reports of potential FWA. The SIU works in tandem with state and federal agencies, and law enforcement to report individuals or organizations who may be involved in FWA activities. CenCal Health relies on its provider partners to identify and report suspected FWA. This section of the Provider Manual should serve as general guidance for providers and other partners in identifying and reporting FWA to CenCal Health.

In addition, CenCal Health's website includes sections dedicated specifically to FWA concerning Members and Providers. The website highlights many of the same elements included in this manual and includes:

- A definition of FWA.
- What information reporters should provide to assist in an investigation.
- How to report potential FWA.

Q2 Fraud Waste and Abuse (FWA) Definitions

- **Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.
- **Waste:** The overutilization or inappropriate utilization of services and misuse of

resources.

- Abuse: Activities that are inconsistent with sound fiscal, business, or medical practices, and result in the following: unnecessary cost to healthcare programs or reimbursement for services that are not Medically Necessary or fail to meet professionally recognized standards for healthcare. Abuse also includes beneficiary practices that result in unnecessary cost to healthcare programs.

Q3 Examples of FWA

In general, fraud costs the state and federal taxpayers up to \$260 Billion annually. Below are examples of fraud you may encounter as a healthcare provider of State-sponsored programs.

- Member/Beneficiary/Recipient:
 - Impersonation: Someone using personal information of another person to obtain Medi-Cal or Medicare benefits for which he or she would otherwise not qualify or be entitled to receive.
- Provider:
 - Payment for Referrals: When an individual or provider recruits and pays individuals money or offers gifts in exchange for referrals in the Medicare or Medi-Cal program.
 - Balance Billing: A provider charging a Medicare or Medi-Cal beneficiary for the difference between the allowed reimbursement rate and the customary charge for the service.
- Provider Billing and Coding Issues:
 - Billing for services not rendered.
 - Billing for services at a frequency that indicates the provider is an outlier as compared with their peers.
 - Billing for non-covered services using an incorrect CPT, HCPCS and/or Diagnosis code in order to have services covered.
 - Billing for services that are actually performed by another provider;
 - Up-coding.
 - Unbundling services that should be billed together.
 - Billing for more units than rendered.
 - Services performed by an unlicensed provider, yet billed under a licensed provider's name or information.
 - Altering records to receive covered services.

Q4 Reporting Fraud, Waste or Abuse (FWA)

Under the terms of the contract between CenCal Health and the Provider, the Provider or its subcontract is required to report suspected cases of FWA.

CenCal Health supports good faith and anonymous reporting through a variety of reporting channels accessible to all employees, members, business partners, and the public without fear of retaliation.

When Reporting Fraud, Waste or Abuse please provide as much of the following information as possible:

- Name, Address, License or Insurance ID of suspect (if known).
- Description and Details of the Incident: who, what, where, when, date and time of



incident(s).

- Any documentation you may have related to the incident(s).
- Your name, telephone number (if you would like to be contacted).

Any person may report a compliance or FWA matter to CenCal Health through the following means:

- Anonymously, to the Compliance Hotline: (866) 775-3944
- By Fax: (805) 681-8279; ATTN: Compliance Department
- By E-mail: compliance@cencalhealth.org
- By Mail: CenCal Health
Attn: Compliance Department
4050 Calle Real
Santa Barbara, CA 93110
- The Compliance Alert Line: <https://cencalhealth.alertline.com/gcs/overview>
- The CenCal Health website: <https://www.cencalhealth.org/providers/suspect-fraud/>
- Or, by contacting a CenCal Health Compliance staff member

The Compliance Hotline is available in both English and Spanish and can receive tips 24-hours a day, 7-days a week. The Compliance Hotline is operated by a third-party vendor to maintain confidentiality for the reporter.

You may also report FWA to the following external agencies, directly:

Department of Health Care Services (DHCS)

- Phone: (800) 822-6222
- Online: <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx>

California Department of Justice, Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA)

- Phone: (800) 722-0432
- Online: <https://oag.ca.gov/bmfea/reporting>

Office of Inspector General:

- Phone: (800) HHS-TIPS (800-447-8477)
- Online: <https://oig.hhs.gov/fraud/report-fraud>

Q5: Health Insurance Portability and Accountability Act (HIPAA):

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that requires CenCal Health and its network Providers to protect the security and maintain the confidentiality of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights.

PHI is any individually identifiable health information, including demographic information. PHI includes but is not limited to a member's name, address, phone number, medical

information, social security number, ID card number, date of birth, and other types of personal information.

This section of the Provider Manual seeks to guide Providers on the following: 1) implementation of safeguards to protect CenCal Health member PHI; 2) ensure appropriate uses and disclosures of PHI; 3) ensure members are able to timely access their own PHI; and 4) how to identify and report privacy incidents and breaches to CenCal Health.

Safeguarding PHI

As HIPAA covered entities, CenCal Health and its Providers must comply with HIPAA requirements. Below are a few reminders on how to protect and secure PHI:

PHI in Paper Form

- Documents containing PHI should not be visible or accessible to visitors or others who are unauthorized to have access to PHI.
- When faxing documents containing PHI, verify the recipient, the recipient's fax number, and the documents being sent.
- Ensure that outgoing faxes include a fax cover sheet that contains a confidentiality statement.
- When mailing PHI, verify the recipient, the recipient's mailing address, and the documents being sent.
- Ensure that envelopes and packages are properly sealed, secured, and if using a clear window envelope, ensure that information is not visible through the window of the envelope, prior to mailing out.
- When transporting PHI, ensure that the information is protected by using binders, folders, or protective covers.
- PHI must not be left unattended in vehicles.
- PHI must not be left unattended in baggage at any time during traveling.
- PHI should be locked away during non-business hours.
- PHI must be properly disposed of by shredding. Never recycle or dispose of documents containing PHI in the trash bin.

PHI in Electronic Form

- When transmitting PHI via email ensure that the email is encrypted. This prevents anyone other than the intended receiver from obtaining access to the PHI.
- Do not include PHI such as an individual's name or Beneficiary ID number (CIN) in the subject line of the email.
- Confirm the recipient, recipient's email address, and documents or information being sent, prior to sending the email.
- Ensure all portable data storage devices (CDs, DVDs, USB drives, portable hard drives, laptops, etc) are encrypted.

PHI in Oral Form

- Do not discuss PHI in public areas such as the patient waiting room.
- Do not discuss PHI with unauthorized people. Always verify the identification of an individual, prior to discussing PHI with the individual.
- Ensure to speak quietly when discussing PHI.

Uses and Disclosures of Member PHI

The HIPAA Privacy Rule allows member PHI to be used and disclosed without the member's written consent for the following reasons (not a complete list):

- Verifying eligibility and enrollment
- Authorization for Covered Services
- Claims processing activities
- Member contact for appointments
- Investigating or prosecuting Medi-Cal cases (e.g. fraud, waste, or abuse)
- Monitoring Quality of Care
- Medical treatment
- Case Management/Disease Management
- Providing information to public health agencies as permitted by law
- In response to court orders or other legal proceedings
- Appeals/Grievances
- Requests from State or federal agencies or accreditation agencies

Providers must obtain specific written consent through a HIPAA Compliant Authorization Form for all other uses and disclosures of PHI that do not fall within the list above or are otherwise permitted by the HIPAA Privacy Rule.

Member Access to PHI

The HIPAA Privacy Rule requires CenCal Health and its Providers to provide members, upon request, with access to their PHI. Providers must ensure that their medical records systems allow for prompt retrieval of medical records and that these records are available for review whenever a member requests access to their PHI. Providers must also ensure to provide the member with both timely access to their PHI and provide the PHI in the form and format requested by the member.

Reporting of Privacy Incidents and Breaches to CenCal Health

The HIPAA Breach Notification Rule, requires CenCal Health and HIPAA covered entities to provide notification following a breach of PHI. Providers must immediately and upon discovery report both privacy incidents and breaches involving CenCal Health members. A privacy incident is defined as an event or situation where an individual or organization has suspicion or reason to believe that PHI may have been compromised. Privacy incidents include but are not limited to the following:

- PHI sent to the wrong individual or organization.
- PHI being sent unencrypted.
- Loss or theft of documents containing PHI.
- Loss or theft of unencrypted devices (laptop, hard drives, usb drives).



A breach is defined as an unauthorized access, use, or disclosure of PHI that violates either federal or state laws or PHI that is reasonably believed to have been acquired by an unauthorized person.

Timely reporting of incidents and breaches involving the PHI of our members is crucial in the response, investigation, and mitigation of incidents and breaches. To report suspected or known privacy incidents and breaches you may contact CenCal Health through any of the following means.

Phone: Anonymous Compliance Hotline: 866-775-3944
Fax: 805-681-8279
E-mail: HIPAATeam@cencalhealth.org
Mail: CenCal Health
Attn: Privacy Office
4050 Calle Real
Santa Barbara, CA 93110

Section R: Pharmacy

R1: Medi-Cal Rx – Medi-Cal’s Pharmacy Benefit

Effective January 1, 2022, CenCal Health members will obtain their Medi-Cal pharmacy benefit through a new system. The Department of Health Care Services (DHCS) has given this new system the name, **Medi-Cal Rx**.

Medi-Cal Rx will be administered through DHCS and its vendor, Magellan Medicaid Administration. Magellan will provide a comprehensive suite of administrative services as directed by DHCS, which include claims management/adjudication, utilization management, and customer support.

Medi-Cal Rx is now responsible for administering the following when billed by a pharmacy on a pharmacy claim form.

- Covered Outpatient Drugs, including Physician-Administered-Drugs (PADs)
- Medical Supplies
- Enteral Nutritional Products

Medi-Cal Rx will not include pharmacy services billed as a medical (professional) or institutional claim. Pharmacy services billed on a medical claim will continue to be the responsibility of CenCal Health.

Information regarding Medi-Cal Rx formulary, prior authorization process, and provider portal can be accessed directly from the [DHCS Medi-Cal Rx website](#).

Medi-Cal Rx customer service center can be reached directly at 1-800-977-2273

The CenCal Health Pharmacy Team is also available to answer any questions regarding Medi-Cal Rx at 805-562-1080



URLs for above hyperlinks:

DHCS – Medi-Cal Rx:

<https://medi-calrx.dhcs.ca.gov/home>

CenCal Health Pharmacy Services:

<https://www.cencalhealth.org/providers/pharmacy/>

R2: Medical Pharmacy, Authorizations for Physician-Administered-Drugs (PADs)

CenCal Health and the Pharmacy Services Team is responsible for a variety of activities including, but not limited to:

- Clinical pharmacy adherence
- Drug Utilization Review (DUR)
- Utilization management associated with pharmacy services (Physician-Administered-Drug) billed on a medical and institutional claim.

CenCal Health defines the utilization management of Physician-Administered-Drugs on the medical benefit as **Medical Pharmacy Management**. Medical Pharmacy Management includes clinical guideline criteria, physician-administered-drug authorization request review, and preferred medical pharmacy drug programs.

A comprehensive overview of the Medical Pharmacy Program can be found on the CenCal Health Pharmacy Services webpage. In addition, instructions on how to submit an authorization request through the medical benefit can be found on the CenCal Health Authorizations webpage.

URLs for above hyperlinks:

CenCal Health Pharmacy Services: <https://www.cencalhealth.org/providers/pharmacy/>

CenCal Health Authorization Page: <https://www.cencalhealth.org/providers/authorizations/>

Section S: Forms Library

Claims

www.cencalhealth.org/providers/claims/corrections-disputes-appeals/

[Provider Dispute/Appeal Resolution Request](#)

[Date of Service Claim Correction Form](#)

Facility Site Review

www.cencalhealth.org/providers/facility-site-review/

[Site Review Guidelines](#)

[Medical Record Review](#)

[Physical Accessibility Review Survey \(PARS\)](#)

[Posting for Doctor's Office](#)

[Medical Waste Mailback Sources](#)



- [Tuberculosis \(TB\) Risk Assessment - Adults](#)
- [Tuberculosis \(TB\) Risk Assessment - Children](#)
- [Hearing and Vision Screening](#)
- [Sharps Injury Log](#)
- [Emergency Medication Dosage Chart](#)
- [Medi-Cal PCP Facility Site Review & Medical Record Review Preparation](#)
- [Interim Facility Site Review \(Fax Back\)](#)
- [Your Right To Make Decisions About Medical Treatment](#)
- [About the Staying Healthy Assessment \(SHA\)](#)
- [Staying Healthy Assessment \(SHA\)](#)
- [Alternative Medical Waste Treatment Technologies](#)
- [Recommended Adult Immunization Schedule](#)
- [Recommendations for Preventive Pediatric Health Care](#)
- [Medication Check Log](#)
- [Temperature Log for Refrigerator – Fahrenheit](#)
- [Temperature Log for Freezer – Fahrenheit](#)
- [Referral Log](#)
- [Management of Anaphylaxis](#)
- [Advisory Committee on Immunization Practices](#)
- [Vaccine Administration Record for Adults](#)