CenCal Health is committed to improve the health and wellbeing of our community. In an effort to focus more closely on whole person care, CenCal Health has elected to transition the Behavioral Health benefit in-house effective January 1, 2022.

Claims should be submitted to CenCal Health via Electronic Submission (contact edi@cencalhealth.org for more details), Paper Claims to CenCal Health, PO BOX 948, Goleta, CA 93116-0948, or our Web Portal Restricted Site.

Web Portal Claims Entry Steps:

Begin by navigating to the CenCal Health provider portal by clicking on the **Provider Login** icon located at the top of the CenCal Health's website www.cencalhealth.org .

After clicking on the Provider Portal you will need to enter your individual Username and Password. The username is your email and you can create your password by clicking on the "reset/create your password" function.
If you forgot your password, click the 'Reset/Create your password?' function to reset your account.

The second is a vertical menu down the left hand side of your screen. This is labeled "Providers- Restricted" and specific to options that only contracted providers have the ability to perform.

Authorization, there are four (4) Authorization types that providers can submit online such as the Medical TAR (50-1), Request for Extension of Stay in Hospital (18-1), LTC Authorization Form (20-1), and the PCP Referral Authorization Form (RAF). The main home screen allows a provider to see a list of authorization types , a hyperlink to view a specific authorization, the status, Requesting Provider, and Servicing Provider.

Claims Entry, will take you to the Dashboard where you can enter or view submitted claims.

Downloads drops down to Explanation of Payment (EOP) which is a notice of payment to claim payments. When providers submit a claim, you will receive an EOP that explains the payment and any adjustment(s) made to a payment during the adjudication of claims.

Eligibility allows you to verify eligibility individually member eligibility with CenCal Health, or manage a Batch File so you can view a group of members eligibility status all in one report. It is important to check eligibility before providing a service at every visit

Pharmacy Medical Benefit provides details related to Physician Administered Drugs (PADs), and Medi-Cal Rx

Procedure Pricer is a great tool to review a rate per CPT code. This is not contract specific.

Reports are available for different provider types, but provides our Explain Code List which is a list of definitions for the claims explain codes for paid or denied claims submitted to CenCal Health.

User Management is a specific screen access permission that allows the portal administrator for your group create new username/passwords for staff, and manage their screen permission access as needed.

Claims Entry Module
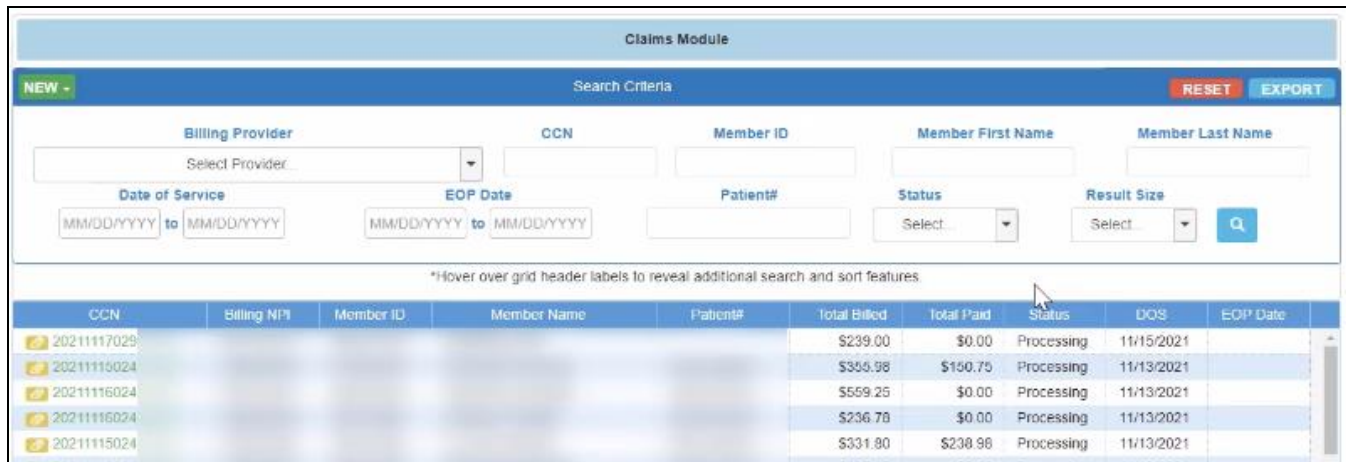
Step 1 - To enter a new claim entry, or view a list of submitted claims, click on Claims Entry, Add/View Claims from the vertical menu. The Claims Module will appear. You may search for submitting claims using any field or any combination of fields within the 'Search Criteria' section.

Once you have entered your filtered search criteria, click on the [search icon] icon to start the search. Your results will populate to the lower grid.

Claims Entry
> Add/View Claims
Training Tutorials
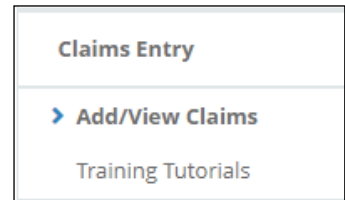
Each column header in the GRID has the ability to sort and filter. By hovering your mouse over the column, 3 lines will appear that you may click on for further options. You may also click on the column title to alphabetize.

Each claim line within the "CCN" column of the Grid will have a paper clip [icon] icon indicating Attachments. By clicking on this icon, you will be taken to a screen that allows you to view existing attachments as well as adding additional attachments.

Step 2 - Click on the green "New" button at the top left and select CMS-1500 to submit a new Health Insurance Claim Form
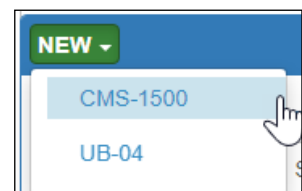
Step 3 - **Member/Provider Information**, Enter the Member ID, the member's Firstname/Lastname or their Date of Birth (DOB). The gender will auto populate. The 'Relationship' category should always be indicated as 'Self' as the 'Child' option should only be used for newborn's using the mother's member ID# in the first 2 months of life. The MRN/Account No. is your internal patient identification if you have them specific to your practice (this is an optional field).

Once the member is successfully populated, you have the option to click on the 'Coverage Info' arrow to view the most recent eligibility information on file with CenCal Health, and determine who the member's assigned Primary Care Physician Group which includes their PCP NPI#, main phone line, and Fax# on file with CenCal Health.

Step 4 - **Provider/Billing Information**, the Billing Provider NPI will auto populate to the number that your login credentials are configured to your group organizational billing number.
Taxonomy - Used to define the category of service and ensure accurate classification of rates.
Referring Provider NPI - NPI is the provider that referred the patient to you and is usually the PCP. (this is not a required field)
Service Facility NPI - Is not applicable to Behavioral Health unless you provided services in a hospital or surgery center type of facility. In this case, please enter the Facility NPI#

Step 5 - **Claim Information** is the body of your claim where you will need to enter the following:
Claim Type- Please use the drop down and click MH/BH
Auth No- please enter the RAFB authorization number here if you received a CenCal Health referral from the members assigned PCP.
SOC- enter the members Share of Cost (SOC) amount paid to you if applicable.
Chrg Amt- This field will auto populated once you enter your billing line item charges in Step 6
Anesthesia Start/Stop time- Leave blank as it is not applicable to your provider type
Delay Reason- You may select a delay reason from the drop down if more than 6 months has passed from the date of service and there is a possibility of a reduction in payment due to untimely filing.
Patient No- This is an optional field for you to enter an ID specific to this individual encounter.
Reserved for Local Use- Remarks- This field is for any additional information you feel is pertinent to the processing of this claim. Examples would include "corrected claim" or "mid-level NPI". If the claim is for a **"AMFT/ACSW/APCC/Psych Assistant",** you may enter their NPI here.

Diagnosis Codes- can be manually entered or by clicking on the search 🔍 icon. You may search by code or description. Please ensure that a description populates beneath each entry. This will confirm the diagnosis is valid and prevent any data entry errors. In the example below, a partial diagnosis has been entered and is therefore invalid.

Diagnosis Codes:*

A [＿＿＿＿＿＿] 🔍
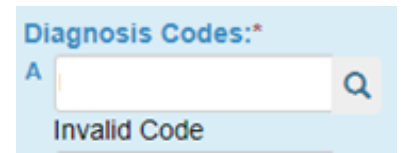
Invalid Code

If you receive an "invalid code" error, you may then use the search tool to enter your diagnosis and be provided with additional options. After locating the correct diagnosis, click on Select.

Search for a ICD Code ✕

Enter: F90 [Search]

	Code	Description
○	F900	Attention-deficit hyperactivity disorder, predominantly inattentive type
○	F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type
●	F902	Attention-deficit hyperactivity disorder, combined type
○	F908	Attention-deficit hyperactivity disorder, other type
○	F909	Attention-deficit hyperactivity disorder, unspecified type

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[1]

[Select] [Cancel]

Diagnosis Codes:*

A F902 🔍

Attention-deficit hyperactivity disorder, combined type

We can now see that the correct description is listed and the "Invalid Code" error has been removed.

Please note that the code provided here is a sample for this instruction guide, and may or may not apply to your claims.

Step 6 - Line Items have 2 rows each with a total of 6 line items available. You can click the [+Add] icon to add 6 more line items for a total of 12 rows.

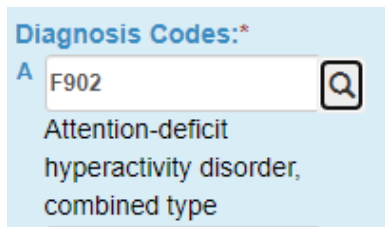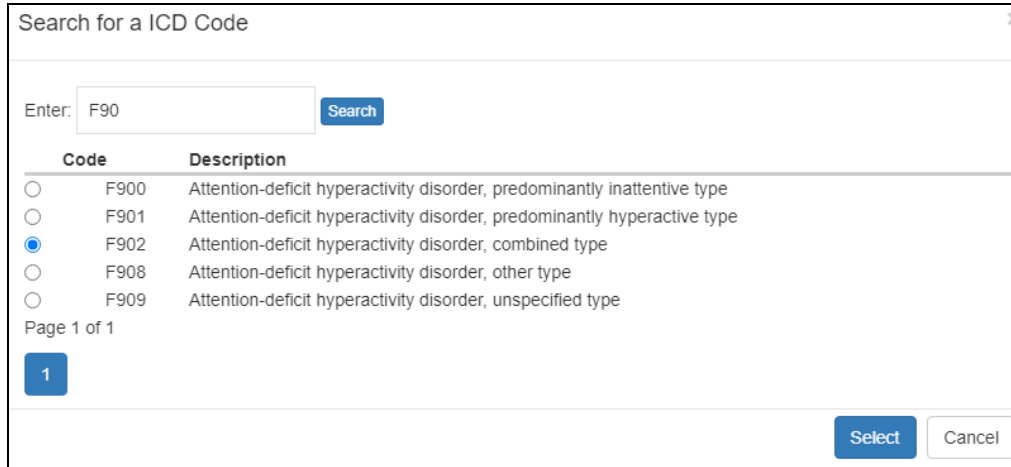| #	Service Date(s)	POS	Emg	Proc	Modifiers 1	2	3	4	Diag Ptr	Charge	Units	Fam Pln EPSDT	Auth No.	Rend NPI	Taxonomy
	NDC/UPN	Code	Quantity	UofM	PaidAmount	CapAmount	Status		Reason Codes						
1	[ ] to [ ]				🔍	∨	∨	∨	∨		0.00	∨			
2	∨					∨	0.00	0.00							

Row 1. The first row is where you will enter the CPT code for the service you have performed.
Service From-Thru dates- if your service occurred on 1 date, this would be the same date in both boxes.
POS- place of service is an indicator for the location of the service. Please see attached list for reference.
EMG- Select Y for Emergency and N for Non-Emergency.
Proc- Enter the procedure or CPT code corresponding to your service. Please see attached list for reference.
Modifiers- Select up to 4 modifiers from the drop down options.
   NOTE: Modifier "HO" indicates that the service was performed by an associate psychotherapist (AMFT, ACSW, APCC), Psych Assistant or an Assistant Behavioral Analyst under the supervision of a licensed/certified clinician. Modifier "HM" indicates that the service was performed by a behavioral technician. For BHT providers, please use HO modifiers for mid-level professional staff and HM for paraprofessionals. No modifier is required for provider level.

Diag Ptr- Enter the letter for each diagnosis field. These will need to be separated by a comma.
Charge Enter your usual and customary billed amount for this service. This should not match your allowed amount exactly so that any change in rate can be accommodated.
Units- This is the quantity. BHT providers please bill in full units, partial units will not be accepted.

<u>Fam Pln/EP SDT</u>- Not Applicable to BH/MH.

<u>Auth No</u>. If you have a TAR for this CPT code enter in this field.

<u>Rend NPI</u>- Enter a rendering NPI here if different from the Group Organizational Billing NPI.
> **NOTE:** However, if claim is for AMFT/ACSW/ APCC/ Psych Assistant, Assistant Behavioral Analyst, Behavioral Technician, Physician Assistant, or nurse who **is not board certified**, please enter the NPI of the fully licensed supervising clinician. If the supervising clinician's NPI is the same as the billing, leave the rendering field blank.

<u>Taxonomy</u>- Enter a Taxonomy here if different from the Billing Taxonomy.

Row 2. The second row is only used for medications being dispensed.

Important Notes
- If a claim is for AMFT/ACSW/ APCC/ Psych Assistant, Assistant Behavioral Analyst, Behavioral Technician, Physician Assistant, or nurse who **is not board certified**, please enter the NPI# of the fully licensed supervising clinician. If the supervising clinician's NPI is the same as the billing, leave the rendering field blank.

- Quantities always have to be billed in whole numbers, our system will deny claims with decimals in the quantity field. If the provider is seeing members for less than 1 hour, they would still have to bill quantity of 1, but can lower their billed charge to reflect the shorter time with the member. Or if billing for more than 1 hour, most codes allow for higher quantity to be billed per day but each "per day limit" is different, so they should verify those limits on the website. Any questions regarding the provider's contract should be directed to your provider service representative.

If this is a secondary claim, you may now enter Other Health Coverage at the line level. By clicking on the COB/OHC drop down arrow at the top of the Line Entry section. You may also add additional service lines
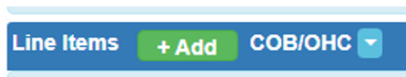
by clicking on the green +Add button. ![Line Items +Add COB/OHC] By clicking on the COB/OHC drop down option, a third row will be added to each line. See below:

Original line with Headers

Third line added for OHC entry

Step 7 – Submit your claim by clicking on the [icon] icon and the system will provide you with a green banner indicating that your 'Claim Created Successfully' or in red 'Claim not created Successfully with missing required fields'. You can then review your claims and see if you have any 'DN' denied status codes and the reason for the denied line item for corrections.

Your claim is now available on the dashboard grid. After the claim has been submitted, you can add attachments if necessary.

Once you have entered all of the claim lines, the 3 icons will be available at the top right after submission. You will also be able to view the current status of the claim at the line level.

The **green +** Add icon allows you to enter a new claim.
The **orange paper clip** icon allows you to upload additional documentation to your claim.

If you see errors on your claim after it has been submitted, the **blue Submit icon** will save any additional changes. After making changes and resubmitting, you will see a "Claim updated successfully" message in green at the top of the screen. The claim number will stay the same.

You may edit the claim up to the time that it appears on the EOP, and click the **blue Save icon**. If you need to make corrections to a claim that already appeared on an EOP, you may do so by submitting a new claim along with the required correction online.

When you are finished entering your claims, you may select the Back to Claim List option on the upper left side of the screen to return to the dashboard.

Once you submit your claim you will receive a **Claim Control Number (CCN)**. Every CCN is a unique identifier for each claim submitted to CenCal Health. The CCN consists of the date the claim is received (e.g. 20211026), the provider type (e.g. 02 is medical), the claim type (e.g. 88 is a Medi-Medi crossover claim), and a sequence number. For website submitted claims, the claim type is 09.

An example of a CCN appears in this format:

Your claim is now available on the dashboard grid. After the claim has been submitted, you can add attachments if necessary.

The **orange paper clip** icon allows you to upload additional documentation to your claim.

    Step 1: Click on the Red "Add" icon at the top right. You may choose
        Initial or Additional attachment Category
    Step 2: Click on "Choose File" to select a document from your
        computer.
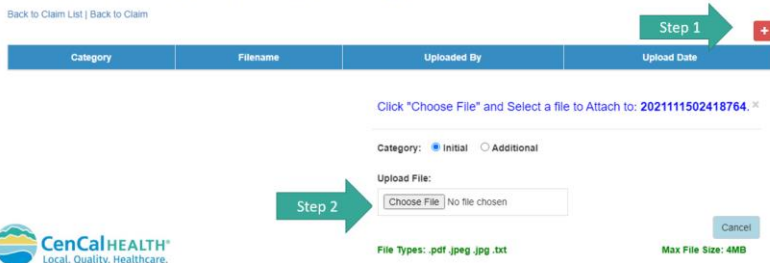
Step 3: After you select a file, click on "Upload Attachments"
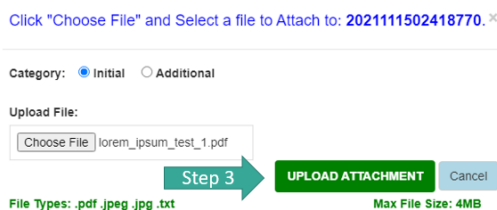
Step 4: Your new attachment will now be visible on the list. It may take a Few moments to load if your attachment is large.

Place of Service/Modifiers/Procedure Code Tips:

Please note there are additional CPT/HCPCS codes that could be included, per your contract. These are the most common used for Behavioral Health/Mental Health claim types. Refer to the National Correct Coding Initiative (NCCI) edits or the California State Medi-Cal manual www.medi-cal.ca.gov for the full guidelines and restrictions.

Place of Service
11- Office
02- Telehealth

Modifiers
95-Telehealth
HO- Master's degree level, used to identify services performed by an AMFT/ACSW/ APCC/ Psych Assistant
HM- Less than Bachelor's degree level
HN- DHCS has reassigned this modifier, and is no longer valid for behavioral health
HP- This is not on DHCS' list of approved modifiers, and will not be accepted.

Procedure Codes

90785-INTERACTIVE COMPLEXITY
90791- PSYCHIATRIC DIAGNOSTIC EVALUATION (PER SESSION)
90792- PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES (PER SESSION)
90832- PSYCHOTHERAPY, 30 MINUTES WITH PATIENT
90833- PSYCHOTHERAPY, 30 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE
90834- PSYCHOTHERAPY, 45 MINUTES WITH PATIENT
90836- PSYCHOTHERAPY, 45 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE
90837- PSYCHOTHERAPY, 60 MINUTES WITH PATIENT
90838- PSYCHOTHERAPY, 60 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE
90839- PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES
90840- PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTES
90846- FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT), 50 MINUTES
90847- FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT), 50 MINUTES
90849- MULTIPLE-FAMILY GROUP PSYCHOTHERAPY
90853- INDIVIDUAL MEDICAL PSYCHOTHERAPY BY A PHYSICIAN; 20-30 MINS
90880- HYPNOTHERAPY
90899- UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE
96105- ASSESSMENT OF APHASIA W/INTERPRETATION AND REPORT, PER HOUR
96110- EVELOPMENTAL SCREENING (EG, DEVELOPMENTAL MILESTONE SURVEY, SPEECH AND LANGUAGE DELAY SCREEN), WITH SCORING AND DOCUMENTATION, PER STANDARDIZED INSTRUMENT
96112- DEVELOPMENTAL TEST ADMINISTRATION (INCLUDING ASSESSMENT OF FINE ANDOR GROSS MOTOR LANGUAGE COGNITIVE LEVEL SOCIAL MEMORY ANDOR EXECUTIVE FUNCTIONS BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS WHEN PERFORMED) BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH INTERPRETATION AND REPORT FIRST HOUR
96113- DEVELOPMENTAL TEST ADMINISTRATION (INCLUDING ASSESSMENT OF FINE ANDOR GROSS MOTOR LANGUAGE COGNITIVE LEVEL SOCIAL MEMORY ANDOR EXECUTIVE FUNCTIONS BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS WHEN PERFORMED) BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH INTERPRETATION AND REPORT EACH ADDITIONAL HOUR
96116- NEUROBEHAVIORAL STATUS EXAM, PHYSICIAN FACE-TO-FACE TIME
96121- NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING REASONING AND JUDGMENT [EG ACQUIRED KNOWLEDGE ATTENTION LANGUAGE MEMORY PLANNING AND PROBLEM SOLVING AND VISUAL SPATIAL ABILITIES]) BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
96130- PSYCHOLOGICAL TESTING EVALUATION SERVICES BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL INCLUDING INTEGRATION OF PATIENT DATA INTERPRETATION OF STANDARDIZED TEST RESULTS

AND CLINICAL DATA CLINICAL DECISION MAKING TREATMENT PLANNING AND REPORT AND INTERACTIVE FEEDBACK TO THE PATIENT FAMILY
96131- PSYCHOLOGICAL TESTING EVALUATION SERVICES BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL INCLUDING INTEGRATION OF PATIENT DATA INTERPRETATION OF STANDARDIZED TEST RESULTS AND CLINICAL DATA CLINICAL DECISION MAKING TREATMENT PLANNING AND REPORT AND INTERACTIVE FEEDBACK TO THE PATIENT FAMILY
96132- NEUROPSYCHOLOGICAL TESTING EVALUATION SERVICES BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL INCLUDING INTEGRATION OF PATIENT DATA INTERPRETATION OF STANDARDIZED TEST RESULTS AND CLINICAL DATA CLINICAL DECISION MAKING TREATMENT PLANNING AND REPORT AND INTERACTIVE FEEDBACK TO THE PATIENT F
96133- NEUROPSYCHOLOGICAL TESTING EVALUATION SERVICES BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL INCLUDING INTEGRATION OF PATIENT DATA INTERPRETATION OF STANDARDIZED TEST RESULTS AND CLINICAL DATA CLINICAL DECISION MAKING TREATMENT PLANNING AND REPORT
96137- PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL TWO OR MORE TESTS ANY METHOD EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
96138- PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY TECHNICIAN TWO OR MORE TESTS ANY METHOD FIRST 30 MINUTES
96139- PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY TECHNICIAN TWO OR MORE TESTS ANY METHOD EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
96146- PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION WITH SINGLE AUTOMATED STANDARDIZED INSTRUMENT VIA ELECTRONIC PLATFORM WITH AUTOMATED RESULT ONLY
99354- PROLONGED SERVICE(S) IN THE OUTPATIENT SETTING REQUIRING DIRECT PATIENT CONTACT BEYOND THE TIME OF THE USUAL SERVICE; FIRST HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR OUTPATIENT EVALUATION AND MANAGEMENT OR PSYCHOTHERAPY SERVICE, EXCEPT WITH OFFICE OR OTHER OUTPATIENT SERVICES **(Can only be billed with 90847)**
99366- MEDICAL TEAM CONFERENCE WITH INTERDISCIPLINARY TEAM OF HEALTH CARE PROFESSIONALS, FACE-TO-FACE WITH PATIENT AND/OR FAMILY, 30 MINUTES OR MORE, PARTICIPATION BY NONPHYSICIAN QUALIFIED HEALTH CARE PROFESSIONAL
99368- MEDICAL TEAM CONFERENCE WITH INTERDISCIPLINARY TEAM OF HEALTH CARE PROFESSIONALS, PATIENT AND/OR FAMILY NOT PRESENT, 30 MINUTES OR MORE; PARTICIPATION BY NONPHYSICIAN QUALIFIED HEALTH CARE PROFESSIONAL