CenCal HEALTH® Local. Quality. Healthcare. 40th ANNIVERSARY 1983 - 2023

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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 alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I Code sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Services, products, therapies that are a covered benefit of CenCal Health, including those services that exceed the services provided by Local Educational Agencies (LEA), Regional Centers (RC) or local governmental agencies 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 And developed with practicing health care providers that is updated when necessary and at least annually.
- 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.
- Has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services, in accordance with the parity in mental health and substance use disorder requirements in 42 CFR section 438.900, et seq.

CenCal is not responsible for the review of Prior Authorizations for Physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient drug claims billed on a pharmacy claim by an outpatient pharmacy.
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 Primary Care Physician 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 Primary Care Physician.

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

Primary Care Physicians, County clinics, family planning providers, gynecologists, mental health providers, 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 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
- Orthotics
    - Therapeutic diabetic shoes and inserts always require prior authorization
- Prosthetics
- 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
- **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 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

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

H4: Referral Authorization Form (RAF) Exceptions

Referral Authorization Form (RAF) is required for all case managed CenCal Health members; however, there are a few 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
- Psychological and Neuropsychological Testing for an underlying Mental Health condition.

Please reference the Authorization section of our website for more information.

Reference Link:
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.

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

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H6: Decision-Making Guidelines

CenCal Health uses the Department of Health Care Services, **Medi-Cal Program's** coverage guidelines t. CenCal Health uses licensed **Milliman Care Guidelines (MCG)** to review authorizations against evidenced based clinical care guidelines. 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 to authorize an amount, duration, or scope that is less than requested are made by a qualified health care professional with appropriate clinical expertise in the medical or behavioral health condition and disease or Long-Term Services and Supports (LTSS) needs.

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

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

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 . Physician Reviewers who hold an active, unrestricted California license make medical decisions. Notice of Action or Notice of Adverse Benefit Determination (Approval, Denial or Modification Determinations) are sent to the Provider via fax, email or mail. Members will receive their Notice of Action or Notice of Adverse Benefit Determination via U.S. mail within 2 working days of the decision. Notices 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 two business days.

Routine (Standard) Request

CenCal Health shall make best efforts to process prior authorization requests promptly. CenCal Health will consult with Providers as needed for Prior Authorization requests for the purposes of determining Medical Necessity for medical services unless doing so would lead

to undue delay in care. Decisions for a routine prior authorization request are usually made within 5- business days of receipt of referral. The decision may be extended up to 14 days from receipt of request. 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.

Urgent (Expedited) Authorization Request
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.

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 in-patient 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.**

Non-Urgent Care Following an Exam in the Emergency Room: CenCal Health will respond to a Provider's request for post-stabilization services within
30 minutes or the service is deemed approved.

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 a 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.

Post-Stabilization: CenCal Health will respond to a Provider's request for authorization for post-stabilization services within 30 minutes or the service is deemed approved in accordance with 22 CCR section 53855(a).

Retrospective Authorization Request for Treatment Received: CenCal Health accepts retrospective authorizations up to 365 calendar days from the date of service. CenCal Health will provide a determination within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S Code section 1367.01(h)(1).

H8: Hospital Discharge Follow-Up Care

CenCal Health provides Transitional Care Services to all Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and state laws and regulations, and DHCS guidance.

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. CenCal Health contracted Providers, and Hospitals, shall ensure that prior authorizations required for the Member's discharge are submitted in accordance with Utilization Management turnaround times.

Please see reference Section I4: Care Transition of the Provider Manual for more information.

H9: Referrals for Specialist Services

Except for emergent, urgently needed services, or Mental Health 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, fax, or secure link at when specialist care is needed for a member.

Please reference Section E7 Mental Health Services of the Provider Manual for more information.

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.

CenCal Health will allow a second opinion from a qualified health professional if available. 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 a qualified health professional within the Network is not available, CenCal will authorize an out of network provider to provide the second opinion at no cost to the member, in accordance with 42 CFR section 438.206. The PCP will submit a RAF via the Provider Portal, secure link or fax to CenCal Health.

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 transitioning to CenCal Health coverage and are receiving services during a 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.

Providers may request continuity of care on behalf of the Member or the member may make that request themselves by contacting Member Services.
CenCal Health members may request continuity of care with any out of network provider with whom the Member has had a pre-existing relationship with or the provider has terminated their contract with CenCal Health. The member must have seen the provider within the past 12 months or 6 months for Behavioral Health Treatment services.

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*
Behavioral Health Referral (RAFB)	Referral from a qualified provider) for Behavioral Health Treatment (ABA) services	Physician, Psychologist or Surgeon	To refer the member for Behavioral Health Treatment (ABA) services.	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, Outpatient mental health, Behavioral Health Treatment, **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	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 and receipt of supporting clinical documentation 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, receipt of supporting clinical documentation 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".