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Section H: Referrals and Authorizations

H1: Medically Necessary (or Medical Necessity) Services

Medically Necessary Services are those services determined to be 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. Services will be in accordance to Health & Safety Code 1367.01 products, therapies are covered benefits 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. Adults 18 years and older do not have to go to their PCP for certain sensitive or private care. 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
- Family Planning and birth control
- AIDS/HIV prevention and testing
- Sexually transmitted disease prevention, 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 services, including emergency contraception.
  - 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)
- Infertility treatments

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 (Fax) for adult members and at (805) 692-5140 for pediatric members.

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)
- 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
- Services in 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 Medicine
  - Submit your request to Care to Care CenCal Health's Radiology Benefit Manager (RBM)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: RAF Exceptions

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

Services that are exempt from the RAF requirement:

- First month of eligibility assigned to CenCal Health as Special Class and/or Members residing in Long Term Care
- Sensitive Services (Family planning, sexually transmitted diseases appointments, abortion and HIV testing)
- Emergency Services
- Mental Health psychotherapy
- Mental Health Medication Management Services
- Psychological and Neuropsychological Testing for an underlying Mental Health condition.

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

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

H5: Limited Service Authorizations

CenCal Health members have access to "Limited Services under the Medi-Cal program, whereby a Member is entitled to two visits or services per month.
Services must be reserved by Providers for each visit to be provided. Services may be reserved by completing and submitting CenCal Health's Medi-Reservation Form found on the CenCal Health Provider Portal. A confirmation number will be given once the service is reserved.

Services Requiring a Medi-Reservation include:

- Audiology
- Chiropractic

For more information about Medi-Reservations, please visit the Medi-Cal website.

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

H6: Medical Decision-Making Guidelines

CenCal Health uses various guidelines to make medical necessity decisions including the Medi-Cal Provider Manual (State criteria), CenCal Health established clinical and medical policies, CenCal Health adopted evidence-based guidelines and Milliman Care Guidelines (MCG).

When none of the above sources have clear and specific 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).

CenCal Health reserves the right to use a board-certified specialist and/or an external review organization to assist in decision-making.

CenCal Health Policy Reference:
UM-MM22 Clinical Criteria for UM Decisions

Reference Link:
DHCS Durable Medical Equipment (DME): Oxygen and Respiratory Equipment (dura oxy)
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=duraoxy.pdf

DHCS Audiology and Hearing Aids (AUD)
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/community/audiology-and-hearing-aids

DHCS Orthotics and Prosthetics (OAP)
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=orthotics-and-prosthetics

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
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=durable-medical-equipment-and-medical-supplies

H7: Urgent (Expedited) and Urgent Care

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 member's 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

Urgent Care

Urgent Care are 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 applies to 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:

- Minor 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
- 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

H8: Hospital Discharge Follow-Up Care/Transitional Care Services

CenCal Health provides Transitional Care Services (TCS) 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 planning for the member in coordination with CenCal Health's TCS team. Hospital shall 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 services post discharge. Hospitals shall promptly and openly communicate with CenCal Health's TCM team for appropriate prior authorizations needed to plan for members' discharge.

CenCal Health Policy Reference:
HS – MM44 – Transitional Care Services

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 when specialist care is needed for a member.

Please see E7 Mental Health Services.

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 (excluding sensitive 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 within the Network, 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.

CenCal Health Policy Reference:
MM-UM02 Second Medical Opinion

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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

Members are eligible for Continuity of Care in the following conditions:

- New Members who mandatorily transitioned from Medi-Cal Fee For Service to enroll as CenCal Health Members on or after January 1, 2023, have the right to request Continuity of Care. Members may request up to 12 months of Continuity of Care with a provider if a verifiable pre-existing relationship exits with that Provider.
- New Members who wish to continue care with a terminated provider
    - If CenCal Health is not able to come to an agreement with the terminated Provider or non-participating Provider, or if the Member, Authorized Representative, or Provider does not submit a request for the completion of Covered Services by said Provider, CenCal Health is not required to continue the Provider's services.
- New Members, in accordance with State law, and/or CenCal Health's contractual terms and requirements within the Department of Health Care Services, in which the new member has the right to request continuity of care.
- New Members in accordance with appropriate application of continuity of care in accordance with the Department of Health Care Services Managed Care Program Data Improvement Project.
- Current members whose mental health condition has stabilized, such that the member no longer qualifies to receive Specialty Mental Health Services form the Mental Health Plan, and they become eligible to receive Non-Specialty Mental Health Services from CenCal Health.

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 for up to 12 months. The member must have seen the provider within the past 12 months and CenCal Health determines a pre-existing relationship (self-attestation is not enough).

CenCal Health does not provide continuity of care for services not covered by Medi-Cal, transportation, radiology, laboratory, dialysis centers, ancillary services; and non-enrolled Medi-Cal Providers.

CenCal Health Policy Reference:
HS-MM08 Continuity of Care

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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)	Recommendation from a qualified provider) for Behavioral Health Treatment (ABA) services	Physician, Psychologist or Surgeon	To recommend 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 72 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 72 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".