CenCal HEALTH®
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2024
Provider Manual

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Member Services (877) 814-1861
cencalhealth.org

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Section A: Introduction

A1: Welcome to CenCal Health & Summary of Managed Care

CenCal Health is a County Organized Health System (COHS) model for California's Medi-Cal Managed Care Program that administers health insurance programs for Santa Barbara County and San Luis Obispo County. All Medi-Cal beneficiaries in the service area are automatically enrolled into a COHS program, and each COHS is created by a county board of supervisors and governed by an independent commission. We work with a vast network of dedicated and compassionate doctors, pharmacies, and other types of providers and facilities that take care of our members. CenCal Health provides health coverage for 1 in 4 people in Santa Barbara County, and 1 in 5 in 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, and 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, and is made up of members, providers, business leaders, and local government representatives.

A2: Intent of this Manual

The Provider Manual describes operational policies and procedures for CenCal Health. Topics covered in this Provider 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 and provider grievances, billing, coordination of benefits, reporting, credentialing, and dispute resolution for providers and their staff.

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.

CenCal Health drafted the Provider 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.

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 Provider Manual at (805) 562-1676.

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

Reference Link:
DHCS Medi-Cal Manual
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual

A3: Overview of CenCal Health Programs

CenCal Health is a publicly-funded Medi-Cal Managed Care Health Plan. Once a resident is identified as eligible for Medi-Cal, they are automatically enrolled into the CenCal Health Plan for Santa Barbara and San Luis Obispo County low-income residents. 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, behavioral health (ABA) and mental health providers, Enhanced Care Management (ECM) and Community Supports (CS), 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.

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

A4: Acronyms & Glossary of Terms

CenCal Health uses many acronyms. To view a list of these special, unusual, or technical works or expressions in alphabetical order, please reference the online Glossary of Terms section of our website at cencalhealth.org/explore-cencal-health/glossary-of-terms/

A5: Provider Newsletters & Communication

CenCal Health shares provider news to keep contracted providers, contractors, and subcontractors informed of Medi-Cal updates, CenCal Health campaigns, resources on regulatory requirements, new programs, benefit changes, claims information, clinical updates, pharmacy updates, Behavioral Health (BH) & Mental Health updates, educational opportunities, and more.

The Provider Bulletin Newsletter is a quarterly publication that is printed in March, June, September, and December and sent to contracted provider groups via USPS mail.

In addition, CenCal Health produces monthly digital Provider Pulse E-Newsletters which is emailed to contracted provider groups. All newsletters contain helpful information for all individuals at a provider practice. Individual provider staff are encouraged to sign up to receive an electronic newsletter via email by filling out CenCal Health's electronic registration form.

Non-contracted providers do not receive the quarterly and monthly publications, however, they do have the ability to sign-up for the electronic newsletter via email.

Publications an also be referenced online at cencalhealth.org/providers/provider-bulletin/ .

Reference Link:
Provider Bulletin News
www.cencalhealth.org/providers/provider-bulletin-newsletter/

Provider Bulletin electronic Registration Form
https://cencalhealth.us4.list-manage.com/subscribe?u=7dd3f5945f5855d9526b91b0f&id=ca9deeafab

A6: CenCal Health Mission, Vision, and Values

Our 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 members.

Our Vision: To be a trusted leader in advancing health equity so that our communities thrive and achieve optimal health together.

Our Values:

- **Collaboration -** *Coming together to achieve exceptional results.*
- **Compassionate Service -** *Serving and advocating for all customers with excellence.*
- **Improvement** - *Continually improving to ensure our growth, success, and sustainability.*
- **Integrity** - *Doing the right thing, even and especially when it is hard.*

A7: 2023-2025 CenCal Health Strategic Plan

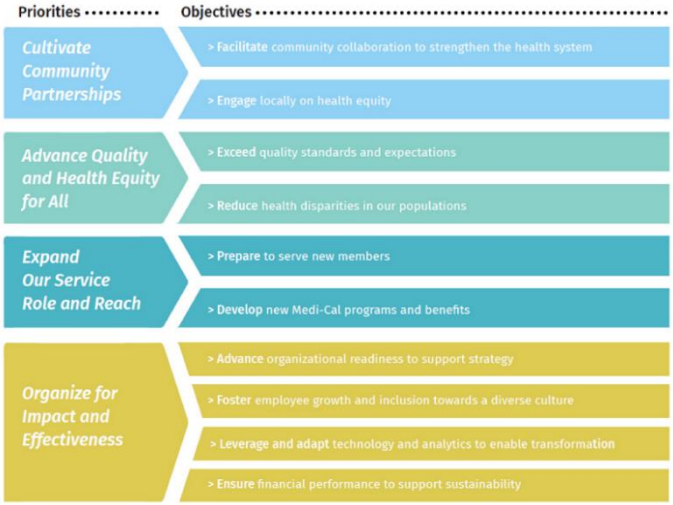
CenCal Health is pleased to share our 2023-2025 Strategic Plan and emerging vision, which prioritizes working with you, our community partners.

Our vision is: To be a trusted leader in advancing health equity so that our communities thrive and achieve optimal health together.

Our priorities are to cultivate community partnerships, advance quality and health equity for all, and expand our service role and reach through the transformational and ground-breaking CalAIM program. This requires that we organize for impact and effectiveness now and in the future. The guidance CenCal Health offers and the priorities it sets have been thoughtfully considered through a broad and inclusive process that began with hearing your voices and then extended to a wide array of stakeholders, including community leaders, local stakeholders, our provider partners, and the members we serve.

Within CenCal Health, we are committed to achieving our Strategic Plan, recognizing that it serves as an important framework going forward. **The value of a local health plan to Santa Barbara and San Luis Obispo counties is more important than ever.** As we turn our attention to the journey we will collectively embark on over the next three years, we look forward to collaborating closely with you, our partners who work tirelessly to improve the health and well-being of our communities.

To read the complete 2023-2025 Strategic Plan, visit cencalhealth.org/strategicplan.



Section B: Provider Resources

B1: CenCal Health Contact Information

Contact Information	Phone Numbers
Member Services	(877) 814-1861
Provider Services & Provider Relations	(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 CalAIM Enhanced Care Management (ECM) & Community Supports (CS) Services (805) 562-1698
Population Health	(805) 617-1997 populationhealth@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 certifiedlanguages.com (877) 814-1861 - Sign Language
Finance-Recoveries Unit	(805) 562-1081 (800) 421-2560 ext. 1081
Fraud, Waste & Abuse Reporting	Chief Compliance Officer & Fraud Prevention Officer (877) 814-1861 Mail: CenCal Health Attn: Fraud Investigations Compliance Department 4050 Calle Real Santa Barbara, CA 93110 Fax: (805) 681-8279 **Email:** compliance@cencalhealth.org

Reference Link:
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 the 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 is located in the 'Forms, Manuals and Policies' section of the website.

Reference Link:
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 Resources and Training Requirements

CenCal Health provides education and training on a variety of topics to CenCal Health's provider network to improve the quality of care and services members receive as Medi-Cal beneficiaries. These training events reflect the most current information available to contracted network providers, contractors, and subcontractors. Trainings may be offered in person or virtually and are also recorded and made available online at cencalhealth.org/providers/provider-training-resources/. Training engagements 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 new providers and rendering practitioners, including subcontractors and downstream subcontractors, credential and contract with CenCal Health, Provider Relations staff will conduct a training to give instructions and materials to help providers become acquainted with CenCal Health's programs including but not limited to member rights & responsibilities, compliance with appointment wait time standards, billing processes, provider/member grievance policy, member eligibility, Cultural Competency, Health Literacy, SPD, Linguistic & translation Interpreter Services, DEI, authorizations, and provider portal website demonstration. The NPO training provides education and training required to operate in full compliance with CenCal Health's Medi-Cal Managed Care Program.

The NPO training is offered within 10 working days and provider have 30 business days to complete the training from the date on which they become active with CenCal Health. A CenCal Health onboarding packet is made available to the provider during onboarding and is inclusive of a full review of CenCal Health policy requirements. The onboarding packet contains much of the information the provider will need to begin to provide care and services to members of CenCal Health's programs, and a New Provider Training Attestation Form is signed stating that the provider received such material. The orientation training may occur online or in person. Provider Relations staff is available by phone, email and in-person for questions and will make return visits as needed.

Provider In-Service Office Visits & Training Visits – Provider Relations staff routinely visit provider offices 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. Additional CenCal Health staff may be included in these meetings, as appropriate.

Routine Training – Training is offered throughout the year via online training webinars for the convenience of Network Providers throughout Santa Barbara and San Luis Obispo counties. It covers a multitude of topics and is designed to expand on the initial instruction and materials provided to new providers. CenCal Health includes routine and ongoing education regarding Member rights and responsibilities.

Claims Billing - This training content is for Network Provider's office staff that are unfamiliar with medical billing for CenCal Health. CenCal Health will educate and train on billing, invoicing, and clean claims submission including education and training about Providers' obligation to refrain from billing Members for Covered Services, even if CenCal Health pays late or denies payment for a claim. Individualized assistance with claims submittal is also available through the Claims department by a Claims Representative. Individualized assistance with claims submittal is also available through the Claims Department by a Claims Representative.

Facility/Medical Record Audit - CenCal Health assists PCP sites in preparing for Facility and Medical Record Audits as required by the Department of Health Care Services (DHCS). Audit tools, relevant policies and procedures, and other related materials are provided to the PCP site when an audit is scheduled, and CenCal Health contacts the PCP site to discuss critical elements and answer questions prior to the audit date. Additional resources, training tools, and guidelines are available online at cencalhealth.org/providers/facility-site-review-and-medical-record-review/.

PCP Quality Improvement Health Equity Trainings - These trainings are held, as needed, to focus on various tools to assist primary care providers in the provision of equitable services to CenCal Health members.

CenCal Health Provider Portal Training - These video training courses are available online and provide education on the various tools available to providers via the Provider Portal. This training includes a demonstration of the provider portal and how to use its features, i.e., checking eligibility, submitting authorizations and referrals, review of various report access, Coordination of Care portal, as well as claim submittal and access to electronic Explanation of Payments (EOP). This training may also be scheduled at the provider's request via an In-Service office training by the Provider Services Representatives for convenience.

Targeted Programs - 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 office managers and hospitals or seminars that relay information on changes to CenCal Health's programs.

Preventive Healthcare – Ongoing trainings on required preventive healthcare services, including Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age, appropriate medical record documentation, and coding requirements. This includes training on existing CenCal Health data collection and reporting requirements, quality improvement programs, Population Health Management Program requirements, health education resources, and provider and Member incentive programs. These trainings are conducted at least once every two years.

Member Access - Education on member access, including compliance with appointment waiting time standards and ensuring telephone translation, and language access is available for members during

hours of operation. Trainings also include education on secure methods for sharing information between CenCal Health, providers, subcontractors, downstream subcontractors, members, and other healthcare professionals, as well as training on how to refer and coordinate care for members who need access to non-Covered Services.

Cultural Competency, Health Literacy and Seniors and Persons with Disabilities - Trains providers on a continuing basis regarding clinical protocols and evidence-based practice guidelines. This training includes an educational program for providers regarding health needs specific to this population and 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 onsite in-service Provider Services staff visit.

Trains providers and staff to 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. This includes but is not limited to education in the provider bulletin, on websites, through provider webinars, as well as outreach through onsite in-service Provider Services staff visits.

All providers must receive Cultural Competency, Health Literacy, and Sensitivity training to better meet the needs of the SPD population. In addition to periodic workshops, sensitivity training materials may be found on the CenCal Health provider website cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-health-literacy/

Emergency Policies and Procedures - Providers will receive training on CenCal Health's Emergency Policies and Procedures. This includes but is not limited to education in the provider bulletin, on the CenCal Health website, through provider webinars as well as outreach through onsite in-service Provider Relations staff visits.

Mandatory bi-annual training, which includes:

a. Information on all member rights and responsibilities as specified in the contract between DHCS and CenCal Health;
b. Diversity, equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training); as specified in Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training) of the contract between DHCS and CenCal Health; and of the contract between DHCS and CenCal Health
c. An educational program for providers regarding health needs to include, but not be limited to, the seniors and persons with disabilities (SPD) population, members with chronic conditions, members with specialty mental health service needs, members with substance use disorder needs, members with intellectual and developmental disabilities, and children with special health care needs; and
d. Social drivers of health and diversity impacts on Members' health care.

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 in person, attendees are given name badges and asked to sign an attendance sheet. This allows the Provider Relations 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" may be created for demonstration purposes.

Monitoring - Attendees are requested to fill out an evaluation form after the training is completed. This allows the Provider Relations 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.

CenCal Health Policy Reference:
PS-CO103 – New Provider Orientation
PS-PS103 – Provider Education and Training

Reference Link:
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

An Advance Health Care Directive is a written legal document that relates to the provision of health care when a member is incapacitated. Advance Directives detail treatment preferences for any health care decisions when a member is unable to speak for themselves. Examples of Advanced Health Care Directives include, but are not limited to, living wills, a Durable Power of Attorney for Health Care form, and an Advance Health Care Directive form. The document must comply with State and federal law.

Members have the right to have an Advance Directive in place. CenCal Health members should fill out an Advanced Health Care Directive, as 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. To implement your right to have an Advance Directive in place, 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.

Advanced Health Care Directive information can be found online at https://www.cencalhealth.org/health-and-wellness/. Enter the "Search" feature and type "Advance Directives" to learn about this process.

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.

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.

The website findhelp.org 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.

To access findhelp.org, you can also visit CenCal Health's website at cencalhealth.org/communityresources.

B6: Telemedicine Policy

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

- 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's website and search "COVID-19 Medi-Cal Services and Telemedicine Notice."

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 Relations department by email at 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.

CenCal Health Policy Reference:
CenCal Health Policy & Procedure PS-CR26 Telehealth Services

Reference Link:
DHCS Telehealth Frequently Asked Questions
https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx

B7: Moral Objection

Providers may have a moral objection to some covered services. Providers have a right to not offer some covered services if they morally disagree with the services. If a provider has a moral objection, providers will help members find another provider for the needed services. CenCal Health can also help members find a provider.

Some hospitals and providers do not provide one or more of these services even if they are covered by Medi-Cal:

- Family planning
- Contraceptive services, including emergency contraception
- Sterilization, including tubal ligation at the time of labor and delivery
- Infertility treatments
- Abortion

To make sure members choose a provider who can give them the care they and their family needs, members can call the doctor, medical group, independent practice association, or clinic they want. Or they can call CenCal Health at **1-877-814-1861 (TTY/TDD 1-833-556-2560 or 711)**. Members can ask if the provider can and will provide the services they need.

These services are available to members. CenCal Health will make sure members and their family members can use providers (doctors, hospitals, clinics) who will give them the care they need. If members have questions or need help finding a provider, they can call CenCal Health at **1-877-814-1861 (TTY/TDD 1-833-556-2560 or 711)**.

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 Relations 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 be credentialed by and have a fully executed contract with CenCal Health. To provide emergent care to any Medi-Cal member, providers need only be enrolled in the State Medi-Cal program.

CenCal Health is required to ensure all contracted providers are enrolled in the DHCS Medi-Cal Program via the State's Provider Application and Validation for Enrollment (PAVE) portal. DHCS-enrolled providers are eligible to provide services to Medi-Cal Fee for Service (FFS) beneficiaries as well as CenCal Health Medi-Cal beneficiaries.

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 with DHCS and have questions, please contact the Provider Relations Department, and our team will assist you with the enrollment process.

Your PSR, as well as staff from other CenCal Health departments, will be available to answer questions, complaints, and concerns, assist with member issues, process claims and authorizations for referrals and/or treatment, and for ongoing training.

Reference Link:
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 allow members to receive and search accurate, up-to-date information regarding physicians, hospitals, clinics, and other providers contracted with CenCal Health's network.

Among other requirements, SB 137 requires CenCal Health to do 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 anything changes in their practice, including when they are no longer accepting new patients, a provider leaves or joins the practice, or the office hours change.

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 Relations Department at (805) 562-1676 or send an email 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 Relations Department for assistance.

C3: Credentialing and Recredentialing

CenCal Health always strives to support provision of the best care possible for 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 enact a rigorous credentialing process because we assume responsibility for managing the healthcare of our members and confirming our providers meet quality standards is part of this responsibility. Well-defined policies and procedures identify the practitioners that are subject to this review, establish the credentials assessed, methodology used to make credentialing decisions, and identify the parties responsible for the credentialing process. Information considered includes (but is

not limited to) licensure, relevant training or experience, and any issues that may affect the course of treatment delivered within the managed care setting. Verification of this information from approved primary sources is essential to establish 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 Verifications (Current at Time of Approval)	MD / DO	DC	DPM	Physician Executive	PA / PA-C	NP / NP-C	CRNA	CNM / LM	Allied Health Providers	Organizations
Providers: NPI / SSN / DOB / Legal Name **Organizations:** NPI / Tax ID / W9	X	X	X	X	X	X	X	X	X	X
Medical / Professional School	X	X	X	X	X	X	X	X	X	N/A
Internship / Residency and/or optional Fellowship	X	X	X	X	N/A	N/A	N/A	N/A	N/A	N/A
Board Certification when applicable and/or required by Provider Type	X	X	X	X	X	X	X	X	X	N/A
Providers: Specialty / Degree Designation **Organizations:** Accreditation if applicable	X	X	X	X	X	X	X	X	X	X
Providers: CA State License to Practice or Certificate / Credential **Organizations**: State Licensure and/or Business Licensure if applicable	X	X	X	X	X	X	X	X	X	X
DEA Certificate with explanation for missing eligible schedules if applicable	X	N/A	X	N/A	X	X	N/A	X	N/A	X
Hospital Admitting Privileges or Alternative Admitting Plan	X	N/A	N/A	N/A	N/A	N/A	N/A	X	N/A	N/A
Proof of Medi-Cal Enrollment or Application Submission for providers with an enrollment pathway	X	X	X	N/A	X	X	X	X	X	X
Supervising Physician or Delegation of Services Agreement	N/A	N/A	N/A	N/A	X	X	N/A	N/A	N/A	N/A

Primary Source Verifications (Current at Time of Approval)	MD / DO	DC	DPM	Physician Executive	PA / PA-C	NP / NP-C	CRNA	CNM / LM	Allied Health Providers	Organizations
Practice or Business Locations and Preferred Credentialing Contact	X	X	X	X	X	X	X	X	X	X
OIG Search	X	X	X	X	X	X	X	X	X	X
NPDB or CIN-BAD Query	X	X	X	X	X	X	X	X	X	X
Providers: Professional Liability Coverage **Organizations:** General and/or Professional Liability Coverage if applicable	X	X	X	X	X	X	X	X	X	X
AMA / AOA Profile	X	N/A	X	X	N/A	N/A	N/A	N/A	N/A	N/A
Complete 5-Year Work History with explanations for any gaps 6 months or longer	X	X	X	X	X	X	X	X	X	N/A
Signed Release of Information and Attestation Questions with applicable explanations	X	X	X	X	X	X	X	X	X	X
Quality Check: Facility Site Review for PCPs; Member Grievances and Peer Review data for Recredentialing	X	X	X	N/A	X	X	X	X	X	X

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

Completed Onboarding documents by provider type are required to initiate the credentialing process. We will accept a current and complete CAQH profile in lieu of a CPPA. Please refer to our website for up-to-date information and forms.

C5: Facility Site, Medical Record and Physical Accessibility Reviews

CenCal Health conducts facility site reviews (FSRs), medical record reviews (MRRs), and physical accessibility reviews (PARs) for all PCPs as a requirement for participation in CenCal Health programs.

Reviews of sites for PCPs that serve SBHI and SLOHI members are conducted utilizing the DHCS Medi-Cal Managed Care Full Scope Site Review Survey and Medical Record Survey Tool. PCP sites must achieve a passing FSR score before members can be assigned to the respective PCPs. The FSR includes an on-site inspection and interview with the office personnel.

The MRR is based on a survey of randomly selected medical records and is composed 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 help in completing CAPs.

After the successful completion of an initial full scope survey, the maximum time 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.

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 CBAS providers that serve a high volume of SPDs. PARS assessments examine access to parking, the exterior building, elevators, the 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 Review/Medical Record Review, please visit the CenCal Health website at www.cencalhealth.org or email Provider Relations for assistance at psrgroup@cencalhealth.org.

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

C6: Member Access to Care Standards

According to DHCS and the Medicaid Managed Care Final Rule: Network Adequacy Standards, CenCal Health is required to monitor 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.

Appointment Time	Standard Time Frame
Non-urgent Primary Care Appointment	Appointment within 10 business days from request
Non-urgent Specialty Appointment	Appointment within 15 business days from request
Non-urgent OB/GYN Specialty Care Appointment	Appointment within 15 business days from request

Non-urgent OB/GYN Primary Care Appointment	Appointment within 10 business days from request
Non-urgent Mental Health (non-psychiatry) Outpatient Services Appointment	Appointment within 10 business days from request
Non-urgent Ancillary Services Appointment (for diagnosis or treatment)	Appointment within 15 business days 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

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

As a provider, it is important to ensure that you notify CenCal Health in writing at least 60 days prior to any changes to your practice that may result in terminating your agreement with CenCal Health. Examples of termination include but are not limited to instances when a provider is moving, retiring, or resigning. CenCal Health is required to notify DHCS of Provider Termination as applicable to our contract.

Per CenCal Health's agreement, and by state and other laws, providers must also ensure access to members' records and other information necessary to ensure coordination/transfer of care to another provider. 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 acknowledgment notice via email and will 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 managing care for CenCal Health members and to assure quality of care in accordance with prevailing, evidence-based, medical standards. The

PCP is the main provider of healthcare services for CenCal Health members and is responsible for the structuring and delivery of healthcare to the provider's 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 rendered by other physicians and/or providers to meet the member's healthcare needs. A member may select a Specialist to be their PCP. In such case, the specialist would be required to fulfill the responsibilities and contractual requirements of a PCP, including completion of the Facility Site Review.

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 but not limited to: 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 management of 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 telephone access, accommodations for urgent care, performance of procedures, and inpatient rounds.
- Coordinate and direct appropriate care for members, including:
    - Initial Health Appointments.
    - 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 there under
- 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 evidence-based treatment guidelines or standards of care that are endorsed by professional and/or specialty medical associations, or 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 in-patients who require immediate treatment for unexpected conditions, require 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, which 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 they 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 the 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 *unless another means of communication to inform said physicians of the services rendered to CenCal Health 's members is agreed to by the parties*.

Notwithstanding the above, Hospital may discontinue sending the PCP or Case Manager a copy of the discharge summary if standardized digital Admission, Discharge, Transfer (ADT) data are technically configured and electronically transmitted to CenCal Health at a mutually agreed upon frequency.

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 ensure that Cultural and Linguistic needs of CenCal Health's members are met. Further information on Providing Culturally Competent Care, go to Section D, D7 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 Member:

- 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 the maximum age limit is 16, the member cannot be removed from case management until their 17th birthday. Typically, reassignments based on age happen automatically.
- Non-Contractual: These reasons (listed below) often involve a 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 the 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 (e.g., 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.

- <u>INAPPROPRIATE reasons to request reassignment of a patient:</u>
    - 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 their 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 a special class is needed:
        - For those members who 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 who have moved out of the county, and for members with certain other circumstances, inform the Member Services department at (877) 814-1861.

If you would like assistance in determining if a particular situation meets the criteria for reassignment requests, or if you have questions about the process, please call Provider Relations at (805) 562-1676.

- <u>Submitting a Reassignment Request via the CenCal Health Website</u>
  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 the 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 is 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 4 p.m.). 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 deadline on 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) 562-1676 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 an 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 people with disabilities.

CenCal Health Services

- Non-Emergency and Non-Medical Transportation - CenCal Health contracts with:
  - Amwest Ambulance: (818) 859-7999
  - Ventura Transit System Inc.: (855) 659-4600

See “Non-Emergency Medical Transportation” in Section E, E9 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 and face to face when criteria is met for American Sign Language and spoken languages.
- *Certified Languages International (CLI) 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 230 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.

Reference Link:
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 U.S. 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 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.

Education: All CenCal Health contracted providers and training on the importance of Cultural Competency, Health Literacy, and Seniors and Persons with Disabilities (SPD). Please visit the Cultural & Linguistic Resources and Cultural Competency & Health Literacy website page at CenCal Health for additional resources and learning opportunities to integrate into your practice.

Reference Link:
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/

D8: Disease Surveillance

Providers are required to comply with reporting obligations relating to contagious, infectious, or Communicable Diseases to both local and state public health authorities.

Communicable Diseases, as defined by 22 CCR Section 2500(a)(8), means an illness due to a specific microbiological or parasitic agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

Providers must report such serious diseases or conditions (or suspected cases of such diseases or conditions) when known, which include those set forth under 17 CCR Section 2500(j). Providers must report members with active Tuberculosis (TB) and members who have treatment resistance or non-compliance issue risks to CenCal Health and the TB control officer of the Local Health Department (LHD) for Direct Observed Therapy (DOT). The report shall be in compliance with the requirements set forth in 17 CCR section 2500. Providers shall also implement any directives issued by the local health officer or other public health authorities. Upon receipt of any such directive, provider and CenCal Health shall comply with and implement directed actions within the time frame required to prevent the spread of contagious, infectious, or communicable diseases or conditions.

CenCal Health Policy Reference:
HS-MM50 – Disease Surveillance Policy

Reference Link:
Reporting to Local Health Authority
View Document - California Code of Regulations (westlaw.com)

D9: Compliance with Statutes and Regulations

Providers shall comply with all applicable federal, state and local laws and regulations, including without limitation: (i) Medicaid and Medi-Cal laws and regulations; (ii) the California Code of Regulations ("CCR"); (iii) privacy laws, including, but not limited to, the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, the Health Information Technology for Economic and Clinical Health ("HITECH") Act, and the California Confidentiality of Medical Information Act; (iv) laws governing the use of federal funds, such as fraud and abuse prevention and detection laws; (v) Americans with Disabilities Act (ADA); and (vi) guidance, executive orders, instructions, letters, bulletins, and policies of regulatory agencies having jurisdiction over CenCal Health and/or Providers.

D10: Data Reporting

Provider data has broad applications across CenCal Health and is collected from a variety of sources: provider onboarding and credentialing documentation, provider rosters, provider change requests, annual provider attestation, claims reporting, and encounter data. Data received from providers must follow protocols for timeliness, consistency, and accuracy for use in reporting and claims payment, and providers agree to submit such data pursuant to standards defined by CenCal Health.

Providers shall supply CenCal Health with necessary reports and information to enable CenCal Health to meet federal and state legal and contractual reporting requirements, including without limitation, data reporting requirements to DHCS, reports pertaining to Covered Services provided to members or provider's financial resources.

In addition, providers are required to attest to their data annually if they are a practice with multiple practitioners or two times per year, if operating in a solo practice. Providers can use the CenCal Health roster for this purpose.

D11: 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 setting. 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 a reasonable timeframe 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 Relations 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 resulting 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 website for a list of required diagnosis codes, and in some cases procedure codes that can be reported on a claim related to HCAC.

CenCal Health Policy Reference:
PS-CR31 – Provider Preventable Conditions

Reference Link:
California Department of Health Care Services
https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx

DHCS's Provider-Preventable Conditions
https://www.dhcs.ca.gov/individuals/Pages/PPC_Reporting.aspx

D12: Secure Data Sharing Methods

The Data Exchange Framework (DxF) and its pivotal role within the California Advancing and Innovating Medi-Cal (CalAIM) initiative launched in January 2022. Its purpose is to facilitate the secure and appropriate exchange of health and social services information from medical, behavioral, and

social service systems in California, providing a patient's full health history and the information needed to provide safe, effective, whole person care.

Certain entities are required to execute a Data Sharing Agreement (DSA), and those entities, along with guidelines associated with this requirement can be found in the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-013 Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework. The DSA is a mandated agreement between hospitals, physician organizations and medical groups, skilled nursing facilities, health plans, clinical laboratories and acute psychiatric hospitals to share patient information safely. Entities required to sign the DSA can access the DxF signing portal on the CalHHS Center for Data Insights and Innovation website https://signdxf.powerappsportals.com. After signing the DSA, most signatories will be required to exchange health and social services information or provide access to health information.

The DSA for the California Human Services Data Exchange Framework, executed in accordance with Health and Safety Code section 130290, is detailed in DHCS APL 23-013 Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework and applies to Network Providers.

CenCal Health understands the purpose of the DSA in facilitating secure and real-time data exchange among participants. The DSA supports compliance with federal, state, and local regulations and outlines the common terms and obligations necessary for effective data sharing.

- Data Sharing improves:
    - Health information creation, including the use of national standards in clinical documentation, health plan records, and social services data.
    - Translation, mapping, controlled vocabularies, coding, and data classification.
    - Storage, maintenance, and management of health information.
    - Linking, sharing, exchanging, and providing access to health information.

Reference Links:
CalAIM Data Sharing Authorization Guidance
www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance.pdf
Department of Health Care Services All Plan Letter 23-013
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-013.pdf

Data Exchange Framework Resources
https://dxf.chhs.ca.gov/for-participants/
https://www.cdii.ca.gov/committees-and-advisory-groups/data-exchange-framework/

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

CenCal Health is responsible for the provision of and access to the programs and Covered Services listed below, and as further detailed in CenCal Health's policies and procedures. 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
- Sexually transmitted disease services
- HIV testing and counseling
- Pregnancy termination and abortion services
- Nurse midwife and certified nurse practitioner services
- Lab tests and X-rays
- Prenatal care
- Immunizations
- Durable medical equipment
- Medical supplies
- Prosthetics and orthotics
- Pediatric preventive services (CenCal Health CHDP Program)
- Minor consent services
- Immunizations
- Physician Administered 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
- Non-Specialty Mental Health Services (NSMHS) for minors
- Behavioral Health Treatment (BHT)
- Medication for Addiction Treatment (MAT)
- Palliative Care
- Indian Health Services programs

CenCal Health Policy Reference:
PS-CR30 – Access to Programs/Covered Services

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 Section F, F1: Dental Services for Medi-Cal Members).
- Substance Use Services (see Section F, 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 Section F, F2: Specialty Mental Health Services).

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

E2.1: Acupuncture Services

CenCal Health members may access Acupuncture services to prevent (limited services –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 limited two-services per month. Additional services may be provided based upon medical necessity through the TAR process. For further instructions on TAR's, please refer to Authorization Section H 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 they practice.

"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 by the Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI).

Audiological Services	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	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 do not benefit from conventional amplification (hearing aids).
Non-Covered Charges	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.

Members enrolled in California Children's Services (CCS) have specific guidelines for audiology and hearing aid benefits. Please refer to CCS Numbered Letter 11-0807.
https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

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: www.cencalhealth.org. A confirmation number will be given once the Service is reserved. For more information on Medi-Reservations please refer to Section H, H5 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 by the Santa Barbara Health Initiative (SBHI) and 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.
- Services limited to the treatment of the spine rendered by a licensed chiropractor.
- 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 can be identified by an Aid Code of 13, 23, 53 or 63 when checking eligibility
- 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 on Medi-Reservations please refer to Section H, H5 of the Provider Manual.

Should a Chiropractor feel that X-rays are necessary, they 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 by the Santa Barbara Health Initiative (SBHI), and the San Luis Obispo Health Initiative (SLOHI) and according to the California Code of Regulations (22 CCR 51319) for Hearing Aids.

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

Covered Hearing Aid Services

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 on Medi-Reservations, please refer to Section H, H5 of the Provider Manual. (Please reference Section E13 for CCS Guidelines as this differs 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.

Covered Services

SBHI, SLOHI, Members – The following Home Health services are Covered Benefits for Santa Barbara Health Initiative (SBHI) and 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. Please refer to the Authorization Section H, H4 for further instructions.

E2.6: Hospice Services

CenCal Health members may access hospice services so that they may receive 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 the 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 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.

Note: Hospice and Palliative care are available to CCS members. Please refer to Section E15 of the Provider Manual.

CenCal Health Policy Reference:
MM-UM11 – Hospice Services

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 guidelines below 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 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 and 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. Still, 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 are 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.

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 by the Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) and include the biological, microbiological, serological, chemical, immunohematology, 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, including genetic and alpha-fetoprotein testing.
- Outpatient hospital and other outpatient facilities: Diagnostic services includes laboratory services.
- Inpatient hospital services: including laboratory services.
- Diabetes management and treatment, including outpatient services and laboratory testing.
- 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

A 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.

Specific Authorization of Laboratory Services

Laboratory services that 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 in need of breastfeeding information. The focus of these lactation consultations is to assess the woman's ability to breastfeed and resolve issues they may have related to 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; please verify authorization requirements in Section H of the Provider 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 that 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 meets 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 – Please refer to Section H of the Provider Manual.

CenCal Health Policy Reference:
MM-UM30 – Long Term Care

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 the normalization of eating patterns and nutritional status and assist with medical monitoring in collaboration with the rest of the treatment team.
    - Nutritional services for members with an eating disorder, irrespective of whether the member is receiving outpatient mental health services through CenCal Health or county mental health.
- 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.

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 2 hours per 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 of the Provider Manual 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 Link:
RAF Exceptions List

https://www.cencalhealth.org/wp-content/uploads/2021/10/202104rafexceptionslist.pdf

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.

The types of 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 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 include:

- Eyeglasses, 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 and eyeglasses when necessary, every two (2) years. A referral from the member's PCP is not necessary.

Authorizations

Prior authorization is required for services, please refer to Section H for authorization guidelines.

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. All eyeglasses

Authorization

Please refer to Section H. 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

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 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 the authorization process, please refer to Section H of the Provider Manual. 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 - 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 provide access to all emergency Covered Services including:

- 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 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 outside the scope of an Emergency Medical Transportation Provider as set forth in the EDS Medi-Cal Provider Manual.

SLOHI 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 who accepted responsibility for the member.

CenCal Health Policy Reference:
MM-UM33 - Emergency Medical Transportation, Non-Emergency Medical Transportation, and Non-Medical (EMT NEMT NMT)

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 per California law (California Code of Regulations - 22 CCR 51321), 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, 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 within 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 the contracted provider is unable to provide the service, CenCal Health will allow outside services from non-contracted providers.

If providing incontinence supplies, please refer to the Protocols for Incontinence Supplies in Section E, E2.7.

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.aspx, 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) 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 are 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 represents the number of months for which the item is being requested to not exceed six (6) months. The Quantity field on a TAR represents the number of items being provided each month. Please do not calculate the total items being requested on the TAR 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. Please add the TAR 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 update your email address, please contact the Provider Services Department at (805) 562-1676.

E2.19: Occupational Therapy

CenCal Health covers occupational therapy services when ordered on the written prescription of a physician, dentist, or podiatrist and rendered by a CenCal provider.

Prescription Requirements

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 be indicated.

The following must be present on the prescription form:

- Signature of the prescribing practitioner
- Name, address, and telephone number of the prescribing practitioner
- Date of prescription
- Medical condition necessitating the service(s) (diagnosis)
- A supplemental summary of the medical condition or functional limitations must be attached to the prescription.
- Specific services (for example, evaluation, treatments, modalities) prescribed
- Frequency of services
- Duration of medical necessity of services. Specific dates and length of treatment should be identified if possible. Duration of therapy should be set by the prescriber; however, prescriptions are limited to six months.
- Anticipated medical outcome as a result of the therapy (therapeutic goals)
- Date of progress review (when applicable)
- Age
- Functional limitations
- Mental status and ability to comprehend
- Related medical conditions
- Delay in achievement of developmental milestones in a child or impairment of normal achievement in an adult.

Eligibility

Occupational Therapy providers must confirm that the member presenting in their office is eligible for services under 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.

Documentation of Services

The Occupational Therapy provider shall document services by completing a claim form and submitting the form to CenCal Health.

Authorizations

Occupational Therapy providers are required to obtain a prescription from the member's physician, dentist, or pediatrist.
Referral Authorization Forms (RAFs) are not required for services under any program.

Nursing Facility Prior Authorization Requirements

Occupational therapy services rendered to NF-A or NF-B recipients require prior authorization. A TAR must be submitted for services that are not included in the per diem rate for a Nursing Facility. Authorization approval is limited to services that:

- 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

For occupational therapy services rendered in a certified rehabilitation center or NF-A or NF-B:
• Limitation of two services per month does not apply.
• Initial and six-month evaluations do not require prior authorization. For billing instructions, refer to "Initial and Six-Month Evaluations" in this section.
• Authorization is required for any additional occupational therapy service beyond the initial and six-month evaluation.
Please refer to the TAR/AR Sections of this Provider Manual for more information.

Billing for Covered Services

Occupational 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 a member's condition is related to employment, then CMS-1500 box 10a must be checked "YES."
- The statement "initial evaluation visit" or "six-month re-evaluation visit" must be entered in the Remarks area/Additional Claim Information (Box 19) of the claim when these occupational therapy services are billed. The initial evaluation document is not required as an attachment to the claim form.

Procedure Codes

Initial and Six-Month Evaluation descriptions below. For additional information on billable procedure codes and rates, please reference DHCS Provider Medi-Cal Manual online at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?q=Medi-Cal%20rates&search=Medi-Cal%20rates

Description
Communication board, non-electric AAC devise
Evaluation-initial 30 minutes, plus report
Case conference and report-initial 30 minutes
Case conference and report-each additional 15 minutes
Occupational therapy preliminary evaluation rehabilitation, Nursing Facility (NF) B, NF-A
Treatment-initial 30 minutes
Treatment-each additional 15 minutes
Home or long-term care facility visit-add
Home or long-term care facility visit-add

Unlisted service
Case consultation and report

Case conference means participation in an organized conference with other health team members who are immediately involved in the care or recovery of the recipient, concerning the status or progress of the recipient, and includes required charting entries (limited to one per recipient per month).

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 receiving payment for submitting claim forms to CenCal Health. Orthotics and Prosthetics services will be considered in accordance with the California Code of Regulations (22 CCR 51315)

"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 for the Orthotic and Prosthetic services they have 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 their 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 CenCal Health members

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 Agreement.

E2.21: Speech Therapy

Type of Services Provided

CenCal Health covers speech therapy services when ordered on the written prescription of a physician or dentist and rendered by a CenCal Health provider.

Speech Therapy Benefits for Members under the age of 21

- Under EPSDT regulations, speech therapy is covered if the service is determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. 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 their office is eligible for services under CenCal Health.

Medi-Services

A Medi-Service reservation is necessary for each outpatient speech therapy visit provided by a CenCal contracted provider. Visits to a CenCal Health member in a nursing facility do not require a Medi-Service reservation; however, a Treatment Authorization Request is required.

Authorizations

Speech Therapy providers are required to obtain a prescription from the member's physician or dentist.

Prescription Requirements

The following must be present on the written prescription or referral:

- Signature of the prescribing practitioner
- Name, address, and telephone number of the prescribing practitioner
- Date of referral
- 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 because of the therapy (therapeutic goals)
- Date of progress review (when applicable)

Recipient Information

The following recipient information should be included on each written referral, when applicable:

- Age
- Developmental status and rate of achievement of developmental milestones
- Mental status and ability to comprehend
- Related medical conditions
  The goal of therapy should be the achievement of intelligibility rather than age-specific qualities or previous condition status, such as with a stroke victim.

Certified Rehabilitation Centers and Nursing Facilities

Speech therapy services rendered to NF-A or NF-B recipients require prior authorization. A TAR must be submitted for services that are not included in the per diem rate. Authorization procedures for speech therapy services rendered in a certified rehabilitation center or Nursing Facility Level A (NF-A) or Level B (NF-B) are:

- Limitation of two services per month does not apply.
- Initial and six months evaluations do not require a TAR.
- A TAR is required for any additional speech therapy service beyond the initial and six-month evaluation.

Billing for Covered Services

Speech Therapy Services:

- Speech Therapy providers shall bill using the provider's valid billing number
- The ICD-10- 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"

Procedures Codes

For additional information on billable procedure codes and rates, please reference DHCS Provider Medi-Cal Manual online at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?q=Medi-Cal%20rates&search=Medi-Cal%20rates

Description
Communication board, non-electric AAC device
Speech-generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time

Speech-generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
Speech-generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
Speech-generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
Speech-generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with device.
Speech-generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
Speech-generating software program for personal computer or personal assistant
Accessory for speech-generating device, mounting system
Accessory for speech-generating device, not otherwise classified
Language evaluation
Speech evaluation
Speech-language evaluation (group), each patient
Speech-language therapy, individual, per hour (following procedures H4300 or H4301)
Speech-language therapy, individual, ½ hour
Out-of-office call (payable only for visits to the first patient receiving services at any given location on the same day)
Speech therapy preliminary evaluation, rehabilitation, SNF, ICF
Speech-generating device (SGD)-related bundled speech therapy service, per visit
Speech-generating device (SGD) recipient assessment
Unlisted speech therapy service

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.
Prior authorization must be obtained for both the 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 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 by modifier RP.

Authorization of the SGD

An Authorization Request requires all 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)

Claim Information

- Services provided in a board and care facility are billed with a Place of Service code of 12 (home) and require a Medi-Service reservation.
- Modifier YW must be added to HCPCS codes x4300 through x4320 for licensed Medi-Cal providers billing for speech therapy services performed by unlicensed graduates working under their supervision to fulfill Required Professional Experience (RPE) for licensure.

E2: Limited Services

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

Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology services will be limited to evaluation and treatment services, durations, and frequency of visits that are reasonable and medically necessary. Services will be subject to authorization and must be in accordance with the California Code of Regulations (*22 CCR 51309, Psychology, Physical Therapy, Occupational Therapy, Speech Pathology and Audiological Services)*

Physical Therapy Services are allowed up to a maximum of eighteen (18) services per year without an authorization. Additional services may be provided based upon medical necessity through the TAR process. For further instructions on TAR's, please refer to Authorization Section H 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 at www.cencalhealth.org.

Billing for Covered Services

- For billing questions please refer to Section K of the Provider Manual or reference the Medi-Cal site for details on covered services.

Authorizations:

"Medi-Reservation" shall mean a method a specific provider of limiting/reserving 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 H of the Provider Manual.

E3: Adult Preventive Services

CenCal Health requires the provision of all preventive health services and medically necessary diagnostic and treatment services for adults in accordance with the most recent United States Preventive Services Task Force (USPSTF) "Guide to Clinical Preventive Services."

Additionally, CenCal Health requires the provision of immunization for adult members in accordance with the most recent adult immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). CenCal Health requires Primary Care Physicians or Advanced Practice Providers to make available this core set of preventive services consistent with the USPSTF and ACIP standards. Copies of these guidelines are available from CenCal Health upon request. Both documents are posted on CenCal Health's Preventive Health Guidelines website page.

Preventive services shall include all medically necessary diagnostic, treatment, and follow-up services, which are necessary given the findings or risk factors identified in the initial health appointment or during visits for routine, urgent, or emergent health care situations. Follow-up services should be initiated as soon as possible but no later than 60 calendar days following the discovery of a problem. Preventive services shall be age-appropriate and may include:

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

Assessment of medically necessary preventive services may be done at any opportunity, but at least during the initial health appointment and routine annual visits thereafter. Routine screenings and preventive services may be included in a provider's capitation or FFS payment. If uncertain, to verify whether a particular screening test is separately billable, please contact a CenCal Health Claims Representative at (805) 562-1083.

CenCal Health requires the provision of age and risk appropriate vaccinations in accordance with the findings of the initial health appointment (IHA) or other preventive screenings. Providers shall document in the members' medical records the receipt of vaccinations and report such information to immunization registries in CenCal Health's service areas in accordance with applicable state and federal laws. Additional details regarding IHA requirements can be found in *Section L7 – Initial Health Appointment*.

If preventive services or vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's medical record which indicates the services were advised, and the Member's or guardian of the Member's voluntary refusal of the services. If preventive services or vaccinations cannot be given at the time of the visit, then medical record entries must demonstrate that the Member was informed how to obtain necessary services, or appropriately referred, or scheduled for an appointment to receive services timely.

CenCal Health updates and publishes the Preventive Health Guidelines (PHG) annually in the *Health Matters/Temas de Salud* member newsletter. CenCal Health also includes the PHG documents in the Member Handbook/Evidence of Coverage and conducts outreach to all Members due for a preventive healthcare visit.

New members are also encouraged to make an initial health appointment within 120 days of enrollment.

CenCal Health Policy Reference:
PS-CR32 Adult Preventive Services

Reference Link:
CenCal Health Preventive Health Guidelines For Adults (English/Spanish Handout)
https://www.cencalhealth.org/members/medi-cal/preventive-health-guidelines/

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
https://www.cencalhealth.org/providers/quality-of-care/

CenCal Health Preventive Health Guidelines
https://www.cencalhealth.org/providers/care-guidelines/preventive-health-guidelines/

All Plan Letter (APL) 22 – 030:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf

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 (Periodicity PDF) and DHCS guidelines (APL 23-005, *Requirements for Coverage of Early And Periodic Screening, Diagnostic, and Treatment Services for Medical Members Under the Age of 21*). 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 https://www.cencalhealth.org/providers/care-guidelines/preventive-health-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 the PCP office
- Health education and anticipatory guidance appropriate to age, including but not limited to counseling about nutrition and physical activity and assessment/discussion of BMI percentile
- 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

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 L7: Initial Health Assessments of the manual.

PCPs should bill for preventive services using standard claim forms. Preventive Medicine Evaluations for pediatric members are covered by CenCal Health. 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.

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."

The CHDP Program will be discontinued effective July 1, 2024, per the Department of Healthcare Services. CHDP services will be covered through CenCal Health's delivery system. Please refer to Section E of the Provider Manual for Covered Benefits and Services.

Reference Link:
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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Behavioral Health Treatment (BHT) services for the treatment of Autism Spectrum Disorder include Applied Behavior Analysis (ABA), and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent

practicable, the functioning of the beneficiary, including those with or without a diagnosis of ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

CenCal Health ensures that all of a member's needs for Medically Necessary BHT services are met across environments, including on-site at school or during virtual school sessions. Educationally necessary BHT services covered by a Local Educational Agency (LEA) and provided pursuant to a Member's Individualized Family Service Plan (IFSP), Individualized Education Program (IEP), or Individualized Health and Support Plan (IHSP) may be covered if Medically Necessary. Additionally, CenCal Health provides supplementary BHT services to address any gap in service caused when the LEA discontinues the provision of BHT services.
A member may meet eligibility for medically necessary Behavioral Health Treatment Services if all of the following criteria are met:

- The member is less than 21 years of age.
- The member is medically stable.
- The member is not in need of 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.
- Behavioral Health Treatment services are recommended as Medically Necessary by a licensed physician, surgeon, or psychologist as medically necessary, regardless of diagnosis.

Medical Necessity

For the EPSDT population, state and federal law define a service as "medically necessary" if the service is necessary to correct or ameliorate defects and physical and/or mental illness and conditions.

A BHT service need not cure a condition to be covered. Services that maintain or improve the child's current health condition are considered a clinical benefit and must be covered to "correct or ameliorate" a member's condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems.

Medical necessity decisions are individualized. CenCal does not impose service limitations on any EPSDT benefit other than medical necessity. CenCal complies with mental health parity requirements when providing BHT services.

Criteria for Services for Members Under the Age of 21

CenCal Health uses clinical criteria and guidelines to determine what services are medically necessary. Each authorization request is reviewed appropriately with the member's medical needs for BHT services in accordance with EPSDT requirements and medically necessary standards of care.

Covered Services

BHT services must be:

1. Medically Necessary
2. Provided and supervised in accordance with a CenCal Health approved behavioral treatment plan that is developed by a BHT service provider who meets the requirements in California's Medicaid State Plan; and,
3. Provided by a qualified autism provider who meets the requirements contained in California's Medicaid State Plan or a licensed provider acting within the scope of their licensure.

The following activities are considered non-covered services:

1. Training of staff
2. 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 is to actively provide treatment, not to just supervise, control, or contain the member/identified client.
3. 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.
4. Assisting the member with academic work, functioning as a tutor, or functioning as an educational aide for the member/identified client in school/daycare or at home.
5. Provider travel time.
6. Transporting parents or other family members.

Medi-Cal does not cover the following as BHT services under the EPSDT benefit:

1. Servies rendered when continued clinical benefit is not expected, unless the services are determined to be Medically Necessary.
2. Provision or coordination of respite, daycare, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person (hereinafter, "Guardian") for costs associated with participation under the behavioral treatment plan.
3. Treatment where the sole purpose is vocationally or recreationally based.
4. 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.
5. Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
6. Services rendered by a parent or legal custodian.
7. Services that are not evidenced-based behavioral intervention practices.

Recommendation and Authorization Process

- An ABA recommendation is required to start the Functional Behavioral Assessment Process with a BHT provider.
- Qualified Providers who meet criteria for recommending BHT services as medically necessary, for any member who is eligible, can submit an ABA Recommendation (RAFB) to the Behavioral Health Department via fax (805) 681-3070, Provider Portal or the Behavioral Health Department secure link.
- Upon completion of the FBA assessment, the BHT provider will submit a Treatment Authorization Request (50-1) to CenCal Health 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, secure link or fax to the Behavioral Health Department at (805) 681-3070
- Timelines for authorization of treatment services are in accordance with standard Medi-Cal guidelines as described in Section H, H7: Timeliness for Authorization Request
- No more than one month and at least 14 days prior to the end of the authorization period, providers should submit a Behavioral Health 50-1 Treatment Authorization Request Form with an updated progress report using an approved template & service log to continue services.
    - The BCBA Provider and parent should sign the Treatment plan.
    - A parent or guardian must sign all Service Logs for direct care service hours provided.
    - Providers must include the documented use of at least one standardized assessment tool, which is an industry standard assessment.

- Providers should account for the provision of services that are less than hours approved by CenCal through Service Logs and Progress Reports.

Provision of Behavioral Health Treatment Services

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.

BHT treatment services

- Credible studies and industry standards support that parent participation is associated with improved outcomes. Providers are responsible for coordinating parent participation with treatment planning and service delivery.
- Some portions of direct services may be provided in the school setting when clinically appropriate and medically necessary. Goals and objectives may, however, not be related to academic functions or duplicated. 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 is 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 may be requested.
- Requests for Direct Supervision Hours: CenCal Health authorizes 2 hours of supervision for every 10 hours of direct treatment in accordance with the general standard of care. Individuals who are a Board Certified Assistant Behavioral Analyst (BCaBA) or a Behavioral Management Assistant (BMA) may currently provide some direct supervision of the paraprofessional in an intervention setting if there is documentation that this mid-level supervision has the BCBA's or BMA's guidance.

    a. Requests for hours above the general standard should be submitted with additional documentation for justification that includes support of the member's individualized treatment plan.

    b. BACB Guidelines (2014) recommends a minimum of 2 hours per week of case supervision when direct treatment is 10 hours a week or less.

- Requests for Indirect Supervision Hours: CenCal Health will approve up to 10 units over the authorization period.

    a. Indirect supervision requests are part of the total supervision hours requested.
    b. Indirect supervision may be completed by a BCaBA or a BMA under the supervision of a BCBA.
    c. Indirect supervision can be used for:
        i. In-office functional analysis and skills assessment
        ii. In-office development of goals/objectives and behavioral intervention plans/reports
        iii. In-office direct staff summary notes
        iv. In office clinical meetings with both paraprofessionals and parents present

Functional Behavioral Analysis (FBA) and Treatment Plan

- Members who meet eligibility criteria for BHT services will be authorized by CenCal for an FBA and the development of a treatment plan by a contracted BHT provider.
- Upon receiving an approved Referral (RAFB), BHT providers are required to submit a Behavioral Health 50-1 Treatment Authorization Request Form with up to 10 hours of H0031 to complete an FBA.

    - Additional assessment hours must be requested with clinical documentation to support medical necessity.
- The initial authorization to complete an FBA will be for 60 days.
    - Providers may request an extension of up to 60 days by submitting a Behavioral Health 50-1 Treatment Authorization Request Form with the referral number via secure link or by fax to the Behavioral Health Department at (805) 681-3070.
- Providers must use at least one industry-approved cognitive and adaptive testing tools to assess the member's age-specific impairments on the FBA.
    - Examples: Vineland, Adaptive Behavioral Assessment System-ABAS, Developmental Assessment of Young Children (DAYC), Social Responsiveness Scare, and Social Emotional Learning Edition (SSIS SEL).
- In the event of a disruption of BHT services lasting 4 or more months, CenCal will approve another FBA.
- 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 maintain medical records that show the date of the first appointment offered, the date of first appointment scheduled, and reason for the difference between offered and scheduled appointments.
- Providers must document all outreach efforts to the parents to schedule the initial appointment. Providers who 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 contact the referring provider.
- Providers that require additional units authorization must submit a Behavioral Health 50-1 Treatment Authorization Request Form with justification to the BH Program via the Provider Portal, secure link or by fax to the Behavioral Health Department at (805) 681-3070.
- Providers must use CenCal Health's FBA template or an approved template that meets Treatment Plan requirements as outlined in APL19-014.

Behavioral Treatment Plan Requirements:

The behavioral treatment plan must be person-centered and based on individualized, specific, measurable goals and objectives over a specific timeline for the member being treated.

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) Clearly states measurable long-, intermediate-, and short-term goals and objectives with dates 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) Each goal must include the member's current level of need (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated, 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, 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, in the home, or other community settings, must be clinically indicated, Medically Necessary and delivered in the most appropriate setting for the direct benefit of the member. BHT service hours delivered across settings, including during school, must be proportionate to the member's medical need for BHT services in each setting.
11) Include an exit plan that is specific, measurable, and individualized.

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 the maximum benefit of services. BHT providers will complete a discharge summary on CenCal Health's 6-month progress report template (or an approved template) and submit to the CenCal Health BH Department.

Coordination of Care

CenCal Health is responsible for the provision of Medically Necessary BHT services and requires providers to coordinate with Local Educational Agencies, Regional Centers, and other entities that provide BHT services to ensure that services are not duplicated.

Behavioral Health Treatment Providers are responsible for coordinating care with the primary care physician, other providers, and entities closely involved with the member's care.

Medically Necessary BHT services are not considered duplicative when CenCal Health has overlapping responsibility with another entity for the provision of BHT services unless the services provided by the other entity is currently being provided, is the same type of service, addresses the same deficits, and is directed to equivalent goals.

Coordination of care activities may include the following:

- Contacting the member's pediatrician if the member may benefit from other therapies, such as Occupational Therapy, Speech Therapy, or other medical services.
- Working closely with all other providers, such as Regional Center and the Local Education Agency to ensure coordination of services and care.
    - CenCal Health contracted providers may determine that BHT services included in a member's IEP are no longer Medically Necessary.
- Referring the member for case management through CenCal Health.

Approved HCPCS Codes:

HCPCS Codes	Description
H0031 per 15 min	Assessment
H0032 per 15 min	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

Billing/Claims:
Please include the appropriate modifiers only on claims submission:

- No Modifier - BCBA Provider
- HO - Midlevel Qualified Autism Professional
- HM – Paraprofessional

CenCal Health Policy Reference:
MM-BH300 Behavioral Health Treatment
HS-UM07 Pre-Service Review
HS-UM37 Coordination of Care for Local Education Agency Services

E7: Mental Health Services

Non-Specialty Mental Health Services (NSMHS) are a covered benefit for CenCal Health members when medically necessary. They may be provided by a PCP within scope of practice, by a licensed mental health professional employed by a CenCal Health contracted FQHC or a provider contracted with CenCal Health.

CenCal Health covers services for members (age 21 and older) with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders as defined by the current Diagnostic Statistical Manual of Mental Disorders.

Members under the age of 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment or the presence of a diagnosis; and members of any age with potential mental health disorders not yet diagnosed.

CenCal Health covers psychotherapy for members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder.

Types of Services Provided:
The following Non-Specialty Mental Health Services (NSMHS) are covered by CenCal Health include:

- Mental Health evaluation and treatment, including individual, group, and family psychotherapy.
- Psychological testing and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for the purposes of monitoring drug therapy.
- Outpatient laboratory, drugs, supplies, and supplements.
- Psychiatric consultation with a member to establish medical necessity for medication management of a psychiatric or behavioral disorder.

Services are covered by CenCal Health even when:

- Services are provided prior to the determination of a diagnosis, during the assessment period, or prior to the determination of whether NSMHS or SMHS access criteria is met.
- Services are not included in an individual treatment plan.
- The member has a co-occurring mental health condition and SUD or,
- NSMHS and SMHS are provided concurrently if those services are coordinated and not duplicated.

CenCal Health also covers up to 20 individual and/or group counseling sessions for pregnant or postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth. Modifier 33 and pregnancy or postpartum diagnosis code must be submitted on claims for counseling given to prevent perinatal depression.
Risk factors for perinatal depression include:

- A history of depression
- Current depressive symptoms (that do not reach diagnostic threshold)
- Certain socioeconomic risk factors such as, low-income, adolescent, or single-parenthood
- Recent intimate partner violence
- Mental health-related factors, such as anxiety symptoms or a history of significant life events

Providers are expected to ensure the frequency of services and treatment plan are in line with the treatment of 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 functioning.

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 (NSMHS) for members under the age of 21 when services correct or ameliorate a behavioral health condition discovered by a screening service. Behavioral Health Services, Non-Specialty Mental Health Services need not be curative or completely restorative to ameliorate a behavioral health condition. Services to sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and covered as EPSDT services.
- In accordance with W&I sections 14059.5 and 14184.402, for individuals 21 years of age or older, as service is “Medically Necessary” services when it is 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 include all DSM V diagnoses as primary focus of treatment **except** neurocognitive disorders, substance-related and addictive disorders.

Services are covered if these diagnoses are co-occurring with a mental health disorder and meet criteria for Non-Specialty Mental Health Services.

Authorizations & Referral Protocols

- Referrals and Authorizations are not required for psychotherapy or medication management services.

- Prior Authorization is required for psychological and neuropsychological testing.
    - The Member's Primary Care Physician (PCP) can direct the member to any contracted Psychologist for a psychological evaluation to start the psychological testing authorization process. A psychological evaluation will determine if psychological or neuropsychological testing is clinically indicated and medically necessary.
    - Rendering/Servicing providers are responsible for submitting a Treatment Authorization Request (TAR) to the Behavioral Health Department via fax (805) 681-3070, provider portal, or the Behavioral Health Department secure link.
- Members can choose to seek and obtain a mental health assessment from a licensed mental health provider at any time.
- Members with positive screening results may be further assessed by their Primary Care Physician or referred to a network mental health provider.
- When the condition is beyond the Primary Care Physician's scope of practice, the primary care provider must refer to a contracted mental health provider first.
- If a member's Primary Care Physician cannot perform the mental health assessment, they must refer the member to an appropriate contracted provider and ensure that a closed loop referral is documented (the member is ensured access, a date/time of appointment is obtained, and the member is followed up to ensure they attended). CenCal Health's Mental Health Providers are required to use DHCS's required Transition of Care tool located on the Behavioral Health webpage.
- To facilitate collaborative services between healthcare providers and mental health providers, providers should request a signed release of information from Members.
- To avoid duplication of services, providers should ensure that member is not receiving services at the County Department of Behavioral Health. A member may receive a non-duplicative service from the County Department of Behavioral Health or County Substance Use Department and CenCal Health simultaneously.
- 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 Behavioral Health Care Coordination Request form to the Behavioral Health Department via fax (805) 681-3070, or the Behavioral Health Department secure link. The Behavioral Health Department will outreach member to facilitate access to the appropriate mental health system of care.

CenCal Contact Numbers

CenCal Health Behavioral Health Department

☎ Member Line: (877) 814-1861
Provider Line: (805) 562-1600
Fax number: (805) 681-3070
Secure Link: https://gateway.cencalhealth.org/form/bh

Santa Barbara County Department of Behavioral Wellness

☎ Access Line (24/7) (888) 868 -1649
Psychiatry Consultation Services: (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 Health 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 duplicate services from the County or another in-network contracted provider.
- Update demographic, office and/or participating provider profile information promptly and in advance.
- Refer members to other participating mental health providers when the member may require care outside of the provider's scope or training.
- Obtain a Release of Information and coordinate care with a member's other health/medical care providers as it supports treatment collaboration.
- Provide continuous care to a member who requires County Specialty Mental Health Services (SMHS) until such time as the member is successfully transitioned to County-level services.
    - Facilitate access to appropriate frequency of sessions as indicated on the member's initial psychosocial assessment and treatment plan.

Initial Psychosocial Assessment

CenCal Health requires that all new members have an initial psychosocial assessment during the initial encounter(s) with their mental health provider.

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.

- Presenting concerns
- Medical history
- Psychiatric history
- History of trauma
- Substance use history
- Developmental history (children and adolescents)
- Allergies/adverse reactions
- Current and past medications
- Risk assessment
- Mental status exam
- Member strengths
- Cultural factors
- Diagnosis validated by clinical data.
- Treatment plan and recommendations

Treatment Plan Requirements

- A **treatment plan** must be developed for each new episode and should be updated as needed to reflect changes/progress of the member. CenCal BH Department recommends that the treatment plan be updated every 6 months for psychotherapy services and annually for medication management services.
- Treatment plans must be consistent with diagnoses and 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 a crisis plan for the member.

Progress Notes and Maintenance of Records Requirements

- Providers must retain a record of the type and extent of each service rendered as well as the date and time allotted for appointments and the time spent with patients (California Code of Regulations [CCR], Title 22, Section 51476[a] and 51476[f]).
- Progress Notes should include what psychotherapy interventions were used and how they benefited the member in reaching their 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:

- Coordinating care with the member's PCP, including but not limited to arranging for referrals to other specialists, including psychological testing.

Referrals to Specialty Mental Health Services

Specialty Mental Health Services are delivered through the county mental health plan and are covered for members who meet the following criteria:

Members 21 years of age and over must meet both criteria 1 and 2:

- Criteria 1: The recipient has one or both of the following:
    - Significant impairment, where impairment is defined as distress, disability or dysfunction in social, occupational or other important services.
    - A reasonable probability of significant deterioration in an important area of life functioning.
- Criteria 2: The recipient's condition in criteria 1 is due to either one or the following:
    - A diagnosed mental health disorder, according to the criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases and Related Health Problems.
    - A suspected mental disorder that has not yet been diagnosed.

Members under 21 years of age must meet either criteria 1 or 2 below:

- Criteria 1: The recipient has a condition putting them at high risk for a mental health disorder due to experiencing trauma evidenced by at least one of the following:
    - Scoring in the high-risk range on a trauma screening tool approved by Medi-Cal.
    - Involvement in the child welfare system
    - Juvenile justice involvement
    - Experiencing homelessness
- Criteria 2: The recipient meets both requirements A and B:
    A. The recipient has at least one of the following conditions:
        - A significant impairment
        - A reasonable probability of significant deterioration in an important area of life functioning.
        - A reasonable probability of not progressing developmentally as appropriate.

        - A need for SMHS, regardless of the presence of impairment, which is not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.
    B. The recipient's condition in requirement A above is due to at least one of the following:
        a. A diagnosed mental health disorder, according to the criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
        b. A suspected mental health disorder that has not yet been diagnosed.
        c. Significant trauma placing the recipient at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

- Medi-Cal requires referring clinicians to complete the Transition of Care Tool for Medi-Cal Mental Health Services when referring members who are receiving services from CenCal Health delivery system to the County's delivery system or adding on services within the other delivery system.
- The decision to transition services to and/or add services must be made by a clinician via a patient-centered shared decision-making process in alignment with CenCal Health's policies. Members must be engaged in the process and appropriate consents must be obtained in accordance with standards of clinical practice.
- The Transition of Care Tool may be completed in person, by phone, or by video conference by a clinician or non-clinician. The decision to refer must be made by a clinician.
- Additional clinical information may be attached, including medical history reviews, care plans or medication lists.
- Referring providers must continue to provide services during the transition period and until the member is connected with a Provider in the new system of care, the provider accepts the new member and medically necessary services have been made available to the member.
- Once referred, CenCal Health Behavioral Health Department will provide updates on the members initial intake assessment date with the County Health Plan.

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:

- Discharge date
- Discharge summary and clinical recommendations

Approved CPT Codes for Billing/Claims

Psychiatric Diagnostic Interviews are reported once 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 has shown a change in functioning or symptoms.

Note: Neurocognitive disorders (for example, dementia) and substance-related and addictive disorders (for example, stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive psychotherapy.

Psychiatric Diagnostic Procedures

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

Psychiatric Diagnostic Evaluation

CPT Code 90791 may be used to bill for psychiatric evaluation without medical services, and 90792 to bill for psychiatric diagnostic evaluation with medical services. Psychiatric diagnostic evaluation must be consistent with the scope of license and competency of the mental health provider and must be documented in the medical record with the following items included:

- Presenting problem/changes in functioning and history of presenting concern
- Mental health and substance use history
- Medical history and current medications
- Social and cultural factors
- Risk and safety factors
- Case conceptualization and diagnostic summary

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 or EMDR services.

Psychotherapy

Individual, family, and group psychotherapy that is evidence-based or incorporates evidence-based components is reimbursable for eligible members.

Individual Therapy

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; please use diagnosis code F99.

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.

CPT Code	Description
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
90880	Hypnotherapy

Family Therapy

- Family can be provided and is reimbursable to adults or children with a mental health condition or for members under the age of 21 who are at risk for behavioral health concerns and for whom clinical literature would support that the risk is significant such that family therapy is indicated but may not have a mental health diagnosis.
- All family members do not need to be present for each session.
- Members under age 21 are entitled to receive up to five family therapy sessions before a mental health diagnosis is required.
- Any diagnostic criteria used should be age-appropriate. (i.e., Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood).
- Family therapy is composed of at least two family members receiving therapy together provided by a mental health provider to improve parent/child or caregiver/child relationships and encourage bonding, resolving conflicts, and creating a positive home environment. The primary purpose of family therapy is to address family dynamics as they relate to the member's mental status and behavior(s).
    - Members under age 21 with a diagnosis of a mental health disorder.
    - Members under age 21 with persistent mental health symptoms in the absence of a mental health disorder.
    - Members under the age of 21 with a history of at least one of the following risk factors:
        - Neonatal or pediatric intensive care unit hospitalization
        - Separation from a parent or caregiver
        - Death of a parent or caregiver
        - Foster home place placement
        - Food insecurity, housing instability
        - Maltreatment
        - Severe and persistent bullying
        - Experience of discrimination, including but not limited to discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability; or
    - Members under the age of 21 who have a parent(s) or caregiver(s) with one or more of the following risk factors:
        - A serious illness or disability
        - A history of incarceration
        - Depression or other mood disorders
        - Post-Traumatic Stress Disorder or other anxiety disorder
        - Psychotic disorder under treatment
        - Substance use disorder
        - Job loss
        - A history of intimate partner violence or interpersonal violence
        - Is a teen parent

Family therapy is also reimbursable on an inpatient basis if the member is an infant (under 1 year of age) who is hospitalized in a neonatal intensive care unit. Claims when the CenCal member is an infant and admitted to a NICU will use diagnosis code P96.9.

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.

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

Reimbursable family therapy models include, but are not limited to:

- Child-Parent Psychotherapy (ages 0 through 5)
- Parent-Child Interactive Therapy (ages 2 through 12)
- Cognitive-Behavioral Couple Therapy (adults)

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 is expected to be at least one and one-half hours in duration.

Providers will submit claims using CPT code 90853 and ICD 10 diagnosis code.

Medical Team Conferences

Case Conferences must include a minimum of two health care professionals from different specialties or disciplines who provide direct care to the patient. Not more than one individual from the same specialty may report 99366-99368 at the same encounter. The limit is one per day, per provider.

Reporting participants should record their role in the conference, contributed information, and subsequent treatment recommendations.

CPT Code	General Code Description
99366	Medical team conference, recipient and/or family present per 30 minutes,
99368	Medical team conference, recipient and/or family not present, per 30 minutes

Medication Management services

Psychiatrists, psychiatric Physician Assistants, and psychiatric Nurse Practitioners may bill for the following evaluation and management codes: 99202 thru 99255, 99304 thru 99337, 99341 thru 99350, and 99417. For more information, refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 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 spent providing psychotherapy services. In other words, time spent on the E/M service and the psychotherapy service may not be bundled but must be indicated separately.

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.

Psychological and Neuropsychological testing

Psychological and Neuropsychological testing requires pre-services authorization. Providers requesting to complete Psychological or Neuropsychological testing must submit a Behavioral Health Treatment Authorization Request (50-1) with a completed Psychological/Neuropsychological Testing Pre-Service Authorization Request Form to the Behavioral Health Department via fax (805) 681-3070, provider portal or the Behavioral Health Department.

Psychological testing is reimbursable when a current medical or mental health evaluation has been conducted, and a specific diagnostic or treatment question still exists which cannot be answered by a psychiatric diagnostic interview and history taking.

Neuropsychological Testing

Neuropsychological testing (CPT codes 96132, 96133, 96136 thru 96139, and 96146 [when billing for neuropsychological testing]) is considered medically necessary:

- When there are mild deficits on standard mental status testing or clinical interview, and a neuropsychological assessment is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging or the expected progression of other disease processes; or
- When neuropsychological data can be combined with clinical, laboratory, and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or
- When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, especially when the information will be useful in determining a prognosis or informing treatment planning by determining the rate of disease progression; or
- When there is a need for pre-surgical or treatment-related cognitive evaluation to determine whether it would be safe to proceed with a medical or surgical procedure that may affect brain function (for example, deep brain stimulation, resection of brain tumors or arteriovenous malformations, epilepsy surgery, stem cell transplant) or significantly alter a patient's functional status; or
- When there is a need to assess the potential impact of adverse effects of therapeutic substances that may cause cognitive impairment (for example, radiation, chemotherapy, antiepileptic medications), especially when this information is utilized to determine treatment planning; or
- When there is a need to monitor progression, recovery, and response to changing treatments in patients with CNS disorders to establish the most effective plan of care; or
- When there is a need for objective measurement of patients' subjective complaints about memory, attention, or other cognitive dysfunction, which serves to inform treatment by differentiating psychogenic from neurogenic syndromes (for example, dementia vs. depression), and in some cases will result in initial detection of neurological disorders or systemic diseases affecting the brain; or
- When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders; or
- When there is a need to determine whether a member can comprehend and participate effectively in complex treatment regimens (for example, surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome patients; transplant or bariatric

surgeries in patients with diminished capacity), and to determine functional capacity for health care decision making, work, independent living, managing financial affairs, etc.; or

- When there is a need to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain injured patients; or
    - When there is a need to establish treatment planning through identification and assessment of neurocognitive conditions that are due to other systemic diseases (for example, hepatic encephalopathy; anoxic/hypoxic injury associated with cardiac procedures); or
    - Assessment of neurocognitive functions to establish rehabilitation and/or management strategies for individuals with neuropsychiatric disorders; or
    - When there is a need to diagnose cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.
- Neuropsychological testing is not considered medically necessary when:
    - The patient is not neurologically and cognitively able to participate in a meaningful way with the requirements necessary to successfully perform the tests; or
- Used as screening tests given to the individual or general populations; or
- Used as a screening test for Alzheimer's dementia; or
    - Administered for educational or vocational purposes that do not inform medical management; or
- Performed when abnormalities of brain function are not suspected; or
    - Used for self-administered or self-scored inventories, or screening tests of cognitive function such as AIMS, or Folstein Mini Mental Status Exam (MMSE); or
    - Repeated when not required for medical decision-making, (for example, to make a diagnosis or to start or continue rehabilitative or pharmacological therapy); or
    - Administered when the patient has a substance abuse background and any one of the following apply:
        - The member has ongoing substance abuse such that test results would be inaccurate; or
        - The member is currently intoxicated; or
    - The member has been diagnosed previously with brain dysfunction, and there is no expectation that the testing would impact the member's medical management.

The appropriate test scoring or written test report procedure code must be billed on the same claim as the test administration. ***Pre-test interviews, pre-test instructions, and test materials are not separately reimbursable***. Compensation for these services has been included in the maximum rate for test administration.

Claims billed with CPT codes 96105, 96116, and 96121 must include an attachment specifying the amount of time spent completing each of the following:

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

CPT Code	General Code Description	Frequency Limits

96132	Neuropsychological testing evaluation services; first hour	One per year, any provider
96133	Neuropsychological testing evaluation services; each additional hour	Two per year, any provider
96136	Psychological or neuropsychological test administration and scoring, two or more tests; first 30 minutes	One per year, any provider
96137	Psychological or neuropsychological test administration and scoring, two or more tests; each additional 30 minutes	Nine per year, any provider
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes	One per year, any provider
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes	Nine per year, any provider
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	One per year, any provider

CenCal Health Policy Reference:
MM-BH301 Mental Health Services
HS-UM38 Authorization for Psychological Testing for Mental Health Conditions

E8: Substance Use Services

CenCal Health provides covered Substance Use Disorder services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older, and pregnant members. These services are covered in the primary care settings and the tobacco, alcohol, and illicit drug screening are completed in accordance with the American Academy of Pediatrics Bright Futures for Children recommendations and United States Preventive Services Taskforce grade A and B recommendations for adults.

Members who are identified as requiring alcohol and/or Substance Use Disorder services must be referred to County Department's Drug Medi-Cal Organized Delivery System (DMC-ODC). For Members receiving alcohol or Substance Use Disorder services through the County's Alcohol and Drug Programs, CenCal Health will continue to provide all Medically Necessary covered services and coordination and referral of services between CenCal providers and other treatment programs or the member.

CenCal providers may prescribe medications for addiction treatment (also known as medication-assisted treatment or MAT) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings.

CenCal Health will continue to provide medical case management services for members receiving Substance Use Disorder services from the County's DMC-ODC/Alcohol and Drug Programs.

Medical Necessity

For members under 21 years of age, Covered Substance Use Disorder services are Medically Necessary if they are necessary to correct or ameliorate a mental health or substance use condition discovered by an EPSDT screening. Substance Use Disorder services need not be curative or

restorative to ameliorate a substance use condition. Substance Use Disorder services that sustain, support, improve, or make more tolerable a substance use condition is considered to ameliorate a substance use condition.

Covered Services

CenCal Health covers all Medically Necessary Substance Use Disorder services for members, including:

- SABIRT services for members 11 years of age and older, including pregnant women.
- Emergency room professional services as described in 22 CCR section 53855.
- Facility charges for emergency room visits that do not result in a psychiatric admission.
- Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services required by members to access Medi-Cal covered Substance Use Disorder services.

Screening

Screening for unhealthy alcohol and drug use is only reimbursable when a validated screening tool is used. Alcohol use screenings are billable using HCPCS code G0442, and drug use screenings are billable using HCPCS code H0049. Validated screening tools include, but are not limited to:

- Cut down Annoyed Guilty Eye-opener Adapted to Include Drugs (CAGE-AID)
- Tobacco, Alcohol, Prescription medication and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents.
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for the geriatric population.

Note: G0442 is reimbursable when the single NIDA Quick Screen alcohol-related question is used without including the additional NIDA Quick Screen questions.

Brief Assessment

When a screening is positive, providers should use an appropriate validated assessment tool to determine whether an alcohol or substance use disorder is present. CenCal Health permits billing for alcohol and/or drug screening when a validated alcohol and/or drug assessment tool is used without initially using a validated screening tool.

Validated assessment tools include, but are not limited to:

- NIDA-modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
  - Alcohol Use Disorders Identification Test (AUDIT)

The AAP recommended assessment tool is available at http://crafft.org.

Brief Interventions and Referral to Treatment

Members whose brief assessment reveals unhealthy alcohol or substance use disorder must be offered a referral for further evaluation or treatment, including medications for addiction treatment (MAT) as appropriate.

CenCal Health reimburses alcohol and/or drug brief intervention services using HCPCS code H0050.

Brief interventions include alcohol misuse counseling, counseling a patient regarding the need for further evaluation, or referral to treatment when an alcohol and/or drug use disorder is suspected. There is no minimum number of minutes for brief interventions, but they must include the following:

- Providing feedback to the patient regarding screening and assessment results
- Discussing negative consequences that have occurred and the overall severity of the problem.
- Supporting the patient in making behavioral changes
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if

Provider resources for brief interventions include:

- Brief Negotiated Interview (BNI):*https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Brief_Negotiated_Interview-Algorithm.pdf*
- The Substance Abuse and Mental Health Services Administration (SAMHSA) website: *https://www.samhsa.gov/sbirt/resources*
- Information about treatment programs may be found at:
    - *https://www.samhsa.gov/find-help/national-helpline* or
    - https://www.dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx

Documentation Requirements

Patient medical records must include:

- The service provided, for example, screen and brief intervention.
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record).
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record).
- If a referral to an alcohol or substance use disorder program was made.

CenCal Health providers must make good faith efforts to confirm whether members received treatment and document when, where, and any next steps following treatment. If a member does not receive referred treatment, providers should follow up with the member to understand barriers and adjust referrals, if warranted.

CenCal Health providers should also attempt to connect with the provider to whom the member was referred to facilitate a warm hand-off to necessary treatment.

- CenCal Health Behavioral Health Department can assist providers in coordinating substance use treatment referrals. CenCal Health Primary Care Providers and Mental Health providers who determine a member would benefit from Substance Use Treatment Services can submitting a Behavioral Health Care Coordination Referral to the Behavioral Health Department via fax (805) 681-3070, provider portal or the Behavioral Health Department secure link.

Billing/Claims

Billing Code	General Code Description	Frequency Limit
99406	Tobacco cessation, 3 to 10 minutes	1 per day
99407	Tobacco cessation, more than 10 minutes	1 per day

G0442	Annual alcohol misuse screening, 15 minutes	1 per year, per provider
H0049	Drug use screening	1 per year, per provider
H0050	Alcohol and drug services, brief intervention	1 per day, per provider

Referral process County Alcohol and Drug Services

San Luis Obispo County Alcohol & Drug Services:

- Members can self-refer or can be referred by a CenCal Health provider by calling the County ACCESS Line at (800) 838-1381 and ensuing they have the following information: 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:

- Members can self-refer or can be referred by a CenCal provider by calling County ACCESS line at (888) 868-1649 and ensuring they have the following information: 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.

CenCal Health Policy Reference:
MM-BH 303 Access to NSMHS, SUD and Referral Completion and Tracking

E9: Non-Emergency Medical Transportation Services and Non-Medical Transportation

Non-Emergency Medical Transportation (NEMT) services are available 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. Services will be in accordance with DHCS Guidelines (APL 22-008, *Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses*).

NEMT requires prior authorization (TAR). A completed and signed 'Physician Certification Statement' (PCS) form is required to authorize NEMT. The PCS 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. To prevent denials or delays of transports, a completed PCS form with the appropriate NEMT type, start date and duration must be received by CenCal Health. 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 the member is being transferred from an emergency department to an inpatient setting or from an acute care hospital immediately following an inpatient stay at the acute level of care to a skilled nursing facility, an intermediate care facility, imbedded psychiatric units, free-standing psychiatric inpatient hospitals or psychiatric health facilities.*

The 'Physician Certification Statement' form must include *all required fields:*

a) Functional Limitations and Justification: 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 and Duration: 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 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.
e) Diagnosis: The physician is required to state the member's diagnosis.

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 the 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 for ensuring 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 the NMT request is determined 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.

CenCal Health Policy Reference:
MM-UM33 - Emergency Medical Transportation, Non-Emergency Medical Transportation, and Non-Medical (EMT NEMT NMT)

E10: Oral Health

Oral health is crucial to the overall health and well-being of infants, children, and adolescents. Tooth decay is one of the most common chronic diseases of childhood. Poor oral health leads to pain, school absenteeism, and an overall negative effect on children's general physical health.

All members less than 21 years of age are required to receive a dental screening and an oral health assessment as part of every periodic assessment, with annual dental referrals beginning with the eruption of the member's first tooth or at 12 months of age, whichever occurs first.

According to The American Academy of Pediatric Dentistry (AAPD), a child should be seen by a dentist starting at 12 months of age and every 6 months thereafter or according to a schedule recommended by the dentist. The care and schedule should be based on the child's individual needs and susceptibility to disease.
If a dental home is unavailable, the child's Primary Care Provider (PCP) or assigned staff should *apply topical fluoride varnish to patients every 6 months.* In the absence of a dental home program that can see a child between the ages of 1 and 4, the PCP should continue to perform oral health risk assessments. The AAPD recommends that health care professionals use the AAP Oral Health Risk Assessment Tool.

Topical application of fluoride varnish is a covered benefit for pediatric CenCal Health members.
The U.S Preventive Services Task Force recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk.

Fluoride varnish 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.

PCPs or trained nurses and medical assistants under the supervision of an ordering provider have an opportunity to help prevent tooth decay by applying fluoride varnish.

Billing for Fluoride Varnish

Use **CPT code 99188** - topical application. Reimbursable for children through age 5.
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.
Fluoride Varnish may be applied by:

- Medical Professionals

- Any trained person with signed guardian permission and under a doctor/dentist prescription or protocol
- In a community setting, such as a school/health fair or government program

CenCal Health covers and ensures that dental screenings and oral health assessments are included for **all members**. This includes referrals to appropriate Medi-Cal dental providers, as well as Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional. Services exclusively provided by dental providers are not covered by CenCal Health. In addition, CenCal Health covers and ensures the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists, but may require prior authorization for medical services required in support of dental procedures.

For questions, please contact our Population Health Team at populationhealth@cencalhealth.org.

Monitoring

To ensure the completion and documentation of these requirements, CenCal Health staff perform randomized medical record audits throughout the year. Findings are shared and discussed with audited PCPs.

Annually, CenCal Health reports to DHCS the percentage of children ages 1 through 20 who received at least two topical fluoride applications within the measurement year.
See *Section L5: Performance Monitoring* for additional detail.

Reference Link:
American Academy of Pediatric Dentistry Oral Health Risk Assessment Tool
https://downloads.aap.org/AAP/PDF/oralhealth_RiskAssessmentTool.pdf

Bright Futures/ AAP Health Promotion: Promoting Oral Health
https://downloads.aap.org/AAP/PDF/Bright%20Futures/BF4_OralHealth.pdf

Bright Futures/ AAP Periodicity Schedule
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

CenCal Health Fluoride Varnish for Childhood Oral Health Training Video
https://vimeo.com/255463545

DHCS All Plan Letter 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf

Fluoride Use in Caries Prevention in the Primary Care Setting
https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary?autologincheck=redirected

U.S. Preventive Task Force Recommendation
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1

DHCS Medi-Cal Accountability Set Reporting Year 2024
https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2024.pdf

E11: Postpartum Care

In alignment with The American College of Obstetricians and Gynecologists (ACOG), CenCal Health requires providers to ensure completion of the first postpartum care visit within the first three weeks

after delivery, followed by individualized, ongoing care as needed, concluding with a comprehensive visit no later than 12 weeks after birth.

The time following birth is a critical time for the birthing person and the infant. To optimize the health and well-being of both, postpartum care should be an ongoing process, with services and support tailored to the patient's needs. More than 80 percent of pregnancy-related deaths are preventable, with most deaths occurring in the 7-365 days after childbirth.

During this postpartum time, the patient is adapting to multiple physical, social, and psychological changes, such as recovering from childbirth, adjusting to changing hormones, and learning to care for a new baby. This transition into what is called the "fourth trimester" can be full of happiness but can also be full of challenges; thus, timely postpartum care is essential to the health and well-being of the birthing person and the infant.

In accordance with the Centers for Medicaid and Medicare Services (CMS) toolkit, providers should follow-up on pregnancy and delivery complications such as gestational diabetes, cardiac and coronary conditions, infections, blood clots, and cardiomyopathy. An assessment of mental health, lactation education, and reproductive health counseling should be standard practice.

Additionally, the distribution of printed education resources should include government assistance programs such as Women, Infant and Children (WIC).

Recommendations

ACOG recommends:

- The first postpartum care visit should be completed within the first three weeks after delivery, followed by individualized, ongoing care as needed, concluding with a comprehensive visit no later than 12 weeks after birth.
- Individualized visits based on a full assessment of physical, social, and psychological well-being.
- For patients who experienced a miscarriage, stillbirth, or neonatal death, timely follow-up with an obstetrician-gynecologist is highly suggested.
- Gynecologists or Primary Care Providers should establish ongoing coordination of care for a birthing person with chronic medical conditions.
- Obstetricians and Gynecologists must utilize the most current standards or guidelines of American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) to ensure members receive quality perinatal and postpartum services.
- Obstetricians and Gynecologists must utilize a comprehensive risk assessment tool for all pregnant members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. The results of the risk assessment must be maintained in the member's record and must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit.

Billing

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 **initiated within 3 weeks after delivery, with ongoing care in accordance with the ACOG recommendations**. 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.

- CPT code Z1038

Doula Services

As of January 1, 2023, doula services are a covered Medi-Cal Benefit. CenCal Health members will now be able to get support from a doula (birth worker) at no cost for prenatal and postpartum visits as well

as during labor and birth, miscarriage, and abortion visits. For a doula to be reimbursed for services, they need to be contracted with CenCal Health. For additional information, please reference Section E19: Doula Services of the manual, or contact the Provider Relations department at (805) 562-1676 or email psrgroup@cencalhealth.org

Referrals

Case Management referrals can be submitted for CenCal Health members. Please visit the CenCal Health website for steps on how to submit a referral: https://www.cencalhealth.org/providers/case-management/

For additional contractual requirements and questions, please contact CenCal Health's Population Health team: populationhealth@cencalhealth.org

Reference Link:

Centers of Medicaid and Medicare Services (CMS) toolkit: https://www.medicaid.gov/sites/default/files/2023-08/ppc-for-state-and-medicaid-toolkit.pdf

ACOG Clinical Guidelines
https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx

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 the 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
     - Tobacco Use Codes: https://ctri.wiscweb.wisc.edu/wp-content/uploads/sites/240/2017/09/icd10.pdf
     - Vape/E-cigarette Use Codes: https://www.cdc.gov/nchs/data/icd/Vapingcodingguidance2019_10_17_2019.pdf
   - Place a chart stamp in the medical chart

3. If identified as a smoker, discuss smoking cessation regimens (quitting options) with the patient.
   - Non-pregnant adults should be prescribed FDA-approved pharmacotherapy.

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 the 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**
  Individual counseling, or brief intervention, can be performed at your office visit and can include one of the following validated counseling methods:
    - 5 As (Ask, Advise, Assess, Assist, Arrange)
      https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.pdf
    - 5 Rs (Relevance, Risks, Rewards, Roadblocks, Repetition)
      https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5rs.pdf
    - Other methods of your choice

Billing:

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) 781-5540

Telephone counseling

Refer patient to the *Kick It California* Helpline at (800) 300-8086

- Give the patient a flyer with contact information for the Kick It California
    - https://kickitca.myshopify.com/collections/all
- Or log onto to Helpline's web referral to refer the patient directly. Helpline counselors will then contact patient's personal phone
    - https://www.kickitca.org/patient-referral

Note: Refer **all** pregnant patients who smoke to *Kick it California*

Notes:

- CenCal Health members who have questions about this benefit or need assistance can call **Member Services** at (877) 814-1861.
- For more information on tobacco cessation clinical guidelines, refer to "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008, " linked below.
- For training on tobacco cessation counseling or related topics, please refer to attachment B in the DHCS resource linked below.

Reference Link:

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")
Treating Tobacco Use and Dependence - Five Major Steps to Intervention (The "5A's") (ahrq.gov)

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

Kick It California
https://kickitca.myshopify.com/collections/all

https://www.kickitca.org/patient-referral

Agency for Healthcare Research and Quality Treating Tobacco Use and Dependence
https://www.ahrq.gov/prevention/guidelines/tobacco/clinicians/update/index.html

Department of Health Care Services APL 16-014
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf

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 pediatric members (0-20 years old). The WCM is a delivery system that is in accordance with DHCS guidelines (APL 21-005, *California Children's Services Whole Child Model Program)* which provides comprehensive, coordinated services for children and youth with special healthcare needs through a patient and family-centered approach, ensuring all necessary care for the whole child is received, not only for the CCS condition. In the WCM, CenCal Health is responsible for Neonatal Intensive Care Unit (NICU) acuity review, High-Risk Infant Follow-Up (HRIF) eligibility, authorization for services, and case management. The WCM 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. CCS members are assigned to a PCP who is CCS paneled and contracted with CenCal Health. Methods to ensure timely access may include member assignment to a specialist as a PCP. In such case, the specialist would be required to fulfill the responsibilities and contractual requirements of a PCP, including completion of the Facility Site Review.

The CCS Counties are responsible for determining CCS eligibility and paneling of CCS providers. 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.

For CCS clients who do not have CenCal Health, the CCS County assumes financial responsibility and care management.

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.

If a provider suspects that a child has a CCS-eligible condition, they should contact the member's Primary Care Physician (PCP) and inform them of such suspicion. The member's PCP will then make a referral to CCS for eligibility review. Referrals could be made to the local County CCS office or CenCal Health.

Referrals

A PCP issues a Referral Authorization Form (RAF) to refer an assigned member to a CCS paneled specialist for medically necessary services not generally provided by a PCP. For a list of services that do not require a RAF, please reference CenCal Health's RAF Exceptions List.

Authorizations

CenCal Health will review requests for services of CCS members based on CCS medical eligibility criteria and guidelines. For services that are not related to the CCS condition, CenCal Health will utilize its current medical necessity criteria.

CCS Eligibility Annual Renewals

CCS eligibility has to be reviewed by the CCS Counties on an annual basis. Providers must send the most recent clinic visit notes and medical records to CenCal Health to ensure that authorizations to CCS specialists or Specialty Care Centers are renewed timely.

CenCal Health Policy Reference:
HS-MM45 - Provider Responsibilities for the Care of CCS and Whole Child Model Members

Reference Link:
CenCal Health Pharmacy Services
www.cencalhealth.org/providers/pharmacy/forms-downloads-fax/

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

CenCal Health's RAF Exceptions List
https://www.cencalhealth.org/wp-content/uploads/2021/10/202104rafexceptionslist.pdf

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

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 of the Provider Manual.

CenCal Health Policy Reference:
HS – MM56 - Community Based Adult Services (CBAS)

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 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. Palliative Care 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

Palliative care is available to adult and pediatric members. 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.

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 (Treatment Authorization Request) for initial Palliative Care assessments and consultations is auto-approved. It includes a 7-day global period for services rendered while exploring the benefit. The request 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 the age of 21. Members may contact CenCal Health directly to self-refer for services. There is an add-on payment for the completion of a POLST (Physician Orders for Life Sustaining Treatment) form.

After completion of the initial assessment and consultation and the member has decided 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 notes.

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.

You can access the Palliative Care located online cencalhealth.org/providers/provider-training-resources/provider-training-library/ .

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), and 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 the organization will contract for some of these services, please describe the contractual arrangements.
- If the organization is not a Hospice and/or Home Health organization, submission of a letter or Memorandum of Understanding (MOU) with local a Hospice and/or Home Health organization(s) who can accept patients who need those services is required.

Reference Link:
CenCal Health Palliative Care Training
https://www.cencalhealth.org/providers/provider-training-resources/provider-training-library/

E16: Diabetes Prevention Program

Description of Diabetes Prevention Program

Diabetes Prevention Program ("DPP") is an evidence-based lifestyle change program, taught by lifestyle 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 and lifestyle coaches rendering for the provider organization must be specially 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 the 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 Testing in Children

All providers who perform periodic health assessments (PHA) on members between the ages of six months to six years (i.e., 72 months) must ensure children are tested for blood lead levels (BLL) **at both 12 months and 24 months of age, and order catch-up testing if missed at either 12 or 24 months**. Federal law requires the testing of children enrolled in Medicaid for elevated blood lead levels as part of required preventive services offered through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. CenCal Health covers this test in accordance with the California Code of Regulations (CCR) to comply with federal and state laws.

Providers must assess and test children following the Bright Futures Periodicity Schedule published by the American Academy of Pediatrics. Upon blood lead testing, providers must follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when reporting and interpreting blood lead levels and determining appropriate follow-up activities, including referrals to the local public health department.

Providers must also:

- Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.

    - This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.
- Document blood lead screening guidance and test results in the child's medical record.
- If the parent(s) or guardian(s) of a child member refuse the blood lead screen test, providers must include a signed statement of voluntary refusal by the member (if an emancipated minor) or the parent(s) or guardian(s) of the member in the child's medical record. If a signed statement is unable to be obtained, the provider must document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record.
    - A refusal form template is provided on the CenCal Health website.

Monitoring

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

On a monthly basis, CenCal Health monitors the prevalence and timeliness of blood lead testing in its membership, using the prevailing industry-standard methodology.
In accordance with DHCS contractual obligations, CenCal Health identifies members less than six years of age with no record of receiving a required lead test.

Providers will be notified monthly of all assigned members due for blood lead screen tests through gaps in care reports, as lead testing is one of the priority measures in CenCal Health's Quality Care Incentive Program (QCIP). These reports are available within the QCIP section of the Provider Portal.

Billing

Blood lead testing is a covered CenCal Health benefit. Providers can bill using CPT procedure code 83655.

For questions or support, please contact the Population Health team at populationhealth@cencalhealth.org

Reference Link:

Bright Futures/ AAP Periodicity Schedule
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

California Department of Public Health Requirements for Blood Lead Reporting
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx

CenCal Health Lead Testing Best Practices
https://www.cencalhealth.org/providers/care-guidelines/epsdt-services/lead-testing/

CenCal Health's Quality Care Incentive Program
https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

CenCal Health Provider Portal
https://web.cencalhealth.org/Account/Login?ReturnUrl=%2F

DHCS All Plan Letter 20-016: Blood Lead Screening of Young Children (Supersedes APL18-017)
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf

Publications for Healthcare Providers and Patients
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/Publications-for-Providers.aspx#

Standard of Care on Screening for Childhood Lead Poisoning
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/screen_regs_3.aspx

Statutes and Regulations
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/leg.aspx

E18: 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.

CenCal Health Policy Reference:
HS-UM07 Notification of Determination and Timeliness

Reference Link:
CenCal Health Pharmacy Services
https://www.cencalhealth.org/providers/pharmacy/

CenCal Health Authorization Page
https://www.cencalhealth.org/providers/authorizations/

E19: Doula Services

As of January 2023, CenCal Health covers Doula Services, which include health education, advocacy, and physical, emotional, and nonmedical support provided before, during, and after childbirth or the end of a pregnancy, including throughout the postpartum period. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

Doula services require a written recommendation that must be submitted to CenCal Health by a physician or other licensed practitioner of the healing arts acting within their scope of practice. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a network provider.

Covered Services

A recommendation for services submitted to CenCal Health via a Treatment Authorization Request may be submitted for the following:

- One initial visit.
- Up to eight additional one-hour visits that may be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery, abortion, or miscarriage.
- Up to two extended three-hour postpartum visits after the end of pregnancy.

These requests will be automatically approved by CenCal Health. The extended three-hour postpartum visits do not require the member to meet additional criteria or receive a separate recommendation. An additional recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice is required if additional visits are medically

necessary during the postpartum period. The additional recommendation can include up to nine additional one-hour postpartum visits and will be reviewed for authorization by CenCal Health.

The initial visit must be no less than 90 minutes. All other visits must be no less than 60 minutes. Visits are limited to one per day per member. Only one Doula may bill for services provided to the same member on the same day. One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery, abortion, or miscarriage support.

Doulas may not bill Medi-Cal for a postpartum visit if they provided overnight postpartum care on the same day for a fee billed to the member.

Doulas are required to document the date and time/duration of services provided to members. Documentation should reflect information on the nature of care and service provided and support the length of time spent with the patient that day. Documentation shall be accessible to the Department of Healthcare Services (DHCS).

Non-Covered Services

Pregnant or postpartum beneficiaries as Medi-Cal Doula services are not covered under Medi-Cal:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Still and video photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure are not covered.

Doulas are not prohibited from teaching classes available at no cost to individuals, including Medi-Cal members to whom they are providing Doula services.

To be eligible for credentialing and contracting with CenCal Health, Doulas must:

- Be at least 18 years old
- Provide proof of an adult/infant Cardiopulmonary Resuscitation (i.e., CPR) certification from the American Red Cross or American Heart Association
- Attest to have completed basic Health Insurance Portability and Accountability Act (HIPAA) training;
- Have a National Provider Identifier (NPI) number (request one at https://nppes.cms.hhs.gov);
- Meet qualification either through the training or experience pathway, as follows:
  - o Training:
    - Certificate of completion for a minimum of 16 hours of training in the following topics:
      - Lactation support
      - Childbirth education
      - Foundations on the anatomy of pregnancy and childbirth
      - Nonmedical comfort measures, prenatal support, and labor support techniques
      - Developing a community resource list
    - Attest that they have provided support at a minimum of three births
  - o Experience:

- Attest that they have provided services in the capacity of a doula either a paid or volunteer capacity for at least five years. The five years of experience in the capacity of a Doula must have occurred within the previous seven years. Attestation to skills in prenatal, labor, and postpartum care as demonstrated by the following:
    - Three written client testimonial letters or professional letters of recommendation from the past seven years. Professional letters from any of the following are acceptable: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven years. **One letter must be from either a licensed provider, a community-based organization, or a DHCS-enrolled doula**

Doulas must complete three hours of continuing education in maternal, perinatal, and/or infant care every three years. Doulas shall maintain evidence of completed training to be made available upon request.

Authorization of Services

Any licensed practitioner may make recommendations for Doula services via a Treatment Authorization Request (TAR), which will include the following covered services and automatically approved by CenCal Health (visits are limited to one per day, per month):

- One initial visit of 90 minutes
- Up to eight additional 1-hour visits that may be provided in any combination of prenatal and postpartum visits
- Support during labor and delivery, abortion, or miscarriage
- Up to two extended 3-hour postpartum visits after the end of pregnancy
- During the postpartum period, an additional TAR is required if extra visits are medically necessary
- Additional recommendations can include up to nine additional 1-hour postpartum visits
- Authorization will be provided on an individual basis based on medical necessity

One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery, abortion, or miscarriage support. Extended three-hour postpartum visits do not require the member to meet additional criteria or receive a separate recommendation.

Additional recommendations from a physician or other healing arts licensed practitioners acting within their scope of practice are required if additional visits are medically necessary during the postpartum period, which can include up to nine (9) additional 1- hour postpartum visits and will be reviewed for authorization by CenCal Health.

Doula service documentation requirements

Doula service providers are required to document the dates and time/duration of services provided to CenCal Health members, which should also reflect information on the nature of the care and service(s) provided to support the length of time spent with the member that day. (For example, documentation might state, “Discussed childbirth education with the beneficiary and discussed and developed a birth plan for 1 hour.”). This allows CenCal Health to provide documentation accessible to the DHCS.

Doula service billing code details

Doula service claims should be submitted with at least one (1) Social Determinants of Health (SDOH) diagnosis code, as the Provider Portal forms require completion of that section to process.

Contracted Doula providers may use these codes for services listed here when submitting claims to CenCal Health.

Prenatal and Postpartum Visits

- Z1032-XP – Extended initial visit 90 minutes
- Z1034-XP – Prenatal visit
- Z1038-XP – Postpartum visit
- T1032-XP – Extended postpartum Doula support, per 15 minutes

Labor and Delivery Support

- CPT® 59409-XP – Doula support during vaginal delivery only
- CPT 59612-XP – Doula support during vaginal delivery after previous caesarean section
- CPT 59620-XP – Doula support during caesarean section

Abortion or Miscarriage Support

- HCPCS T1033-XP – Doula support during or after miscarriage
- CPT 59840-XP – Doula support during or after abortion

Extended initial visit must be for 90 minutes to bill with procedure code Z1032-XP.

All visits are limited to one per day per CenCal Health member and only one Doula may bill for a visit provided to the same member on the same day, excluding labor and delivery.

One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery (including stillbirth), abortion, or miscarriage support.

- Prenatal or postpartum visits billed on the same calendar day as labor and delivery, abortion, or miscarriage support may be billed by a different Doula
- For extended postpartum visits lasting at least three hours, Doulas may bill code T1032-XP (15 minutes per unit) for up to 12 units per visit, up to two visits (24 units) per pregnancy per member provided on separate days

Billing codes for support during labor and delivery are limited to once per pregnancy. Support during labor and delivery can be billed if this service is provided by a Doula provider, whether or not the delivery results in a live birth. Billing codes HCPCS code T1033 for miscarriage support and CPT code 59840-XP for abortion support are each limited to once per pregnancy.

Reference Link:
DHCS Master Publication
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/doula.pdf

Onboarding Packet
/www.cencalhealth.org/providers/join-our-network/credentialing-applications-and-forms/

Social Determinant of Health (SDOH)
cencalhealth.org/providers/social-determinants-of-health/

Doula All Plan Letter 23-024
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL-23-024.pdf

E20: Community Health Worker Services

Community Health Worker (CHW) services became a Medi-Cal benefit on July 1, 2022. CHW services are preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs

may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. Importantly, CHW services provide a mechanism for the delivery of equitable and culturally competent care for CenCal Health members, which align with CenCal Health's Population Health Management program.

Covered Services

CenCal Health covers CHW services for members that meet criteria in accordance with CenCal Health Policy and DHCS requirements, which includes:

- Preventive health services to prevent disease, disability, and other health conditions or their progression to help prolong life and promote physical and mental health
- Screening and assessment not requiring a license and assists a beneficiary in connecting to appropriate services to improve their health
- Individual support or advocacy to assist a beneficiary in preventing the onset or exacerbation of a health condition, preventing injury, or violence
- Asthma Preventive to individuals with asthma, but evidence-based asthma self-management education and asthma trigger assessments may only be provided by asthma preventive service providers who have completed either a certificate from the California Department of Public Health Asthma
- Services may also address issues that include, but are not limited to:
  - Control and prevention of chronic conditions or infectious diseases
  - Mental health conditions and substance use disorders
  - Need for preventive services, perinatal health conditions
  - Sexual and reproductive health
  - Environmental and climate-sensitive health issues
  - Child health and development
  - Oral health
  - Aging
  - Health Education to promote the beneficiary's health or address barriers to physical and mental health care, including providing information or instruction on health topics
- Content must be consistent with established or recognized health care standards
- May include coaching and goal setting to improve a beneficiary's health or ability to self-manage health conditions
  - Health Navigation to provide information, training, referrals, or support to assist beneficiaries to:
    - Access health care
    - Understand the health care system
    - Engage in their own care
    - Connect to community resources necessary to promote a beneficiary's health
    - Address health care barriers, including connecting to medical translation/interpretation or transportation services
    - Address health-related social needs
- CHW Violence Preventive Services
  - Evidence-based, trauma-informed, and culturally responsive preventive services provided by an individual qualified through any of the pathways listed below for the purpose of reducing the incidence of domestic violence, violent injury or reinjury, trauma, and related harms and promoting trauma recovery, stabilization, and improved health outcomes
  - Violence prevention services may be provided to a parent or legal guardian of a CenCal Health member under the age of 21 for the direct benefit of the beneficiary, in accordance with a recommendation from a licensed provider
- Serviced for the direct benefit of the CenCal Health member must be billed under the beneficiary's Medi-Cal ID

- Services are covered by Medi-Cal as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law

If the parent or legal guardian of the beneficiary is not enrolled in Medi-Cal, the CenCal Health member must be present during a session.

CenCal Health will use data-driven approaches to determine and understand populations who should be prioritized for CHW services using social determinants of health data, population health management risk stratification data, utilization data, and input from local providers. Generally, CenCal Health members are eligible for CHW services if the following criteria are met:

- The presence or risk of one or more chronic conditions or environmental health exposure;
- Exposure to violence or trauma;
- The presence of barriers in meeting health needs; or
- The presence of a need that will benefit from the provision of those preventive care services provided by CHWs.

Additional detail regarding member eligibility for CHW services can be found in DHCS All Plan Letter 22-016:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-016.pdf

Servicing Provider

Those individuals wishing to provide CHW services must meet certain qualification requirements. Those requirements include:

- Lived experience that aligns with the Member or population being served
- Professional certification **or** work experience of at least 2,000 hours in the past 3 years

Formal CHW certification, if not present, is required within 18 months of becoming a contracted CHW. Additionally, an annual 6 hours of ongoing training is required for all CHWs.

All CHWs must be supervised by an organization or provider who holds responsibility for ensuring that CHWs meet all training and ongoing education requirements. It is this supervising provider or organization who will contract with CenCal Health and bill for CHW services and will submit to CenCal Health a roster of all CHWs providing services to CenCal Health members. CenCal Health will verify that all applicable requirements are met during the Contracting and Credentialing process.

Minimum Qualifications

- CHWs must have lived experience that aligns with and provides a connection between the CHW and the community or population being served

- This may include but is not limited to, lived experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation.

- Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background of one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

Supervising providers are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving.

CHWs are not required to enroll as a Medi-Cal providers and are therefore not subject to the requirements for Provider Credentialing/Re-Credentialing and Screening/Enrollment.

Training

- No established single standardized curriculum for training CHWs or their employers
- Complete 6 hours (minimum) of additional training annually

Certificate of Completion

- CHWs, not having one, must earn it within 18 months of their first visit to a Medi-Cal member
- Must have completed a training specific curriculum and able to successfully demonstrate their acquired skills

Work Experience Pathway Program (WEP)

- Demonstrated skills and practical training in core competencies, as determined by a Supervising Provider
- CHWs demonstrating qualifications through this program, but do not have a certificate, must earn one within one year of the first CHW visit provided to a Medi-Cal member
- Plan of Care
    - Written document developed by one or more licensed providers, including the support and services a CHW will provide to address ongoing member needs
    - CHWs may assist in developing a plan of care with the licensed provider

Violence Prevention Professional (VPP)

Individuals only providing violence prevention services can obtain a Violence Prevention Professional (VPP) Certification, issued by Health Alliance for Violence Intervention or a certificate in gang intervention training from the Urban Peace Institute.

Supervising Providers

Supervising provider shall be an enrolled Medi-Cal provider who submits claims for CHW services, ensures they meet the qualifications, directly or indirectly oversees a CHW and their services delivered to Medi-Cal beneficiaries, and can be a licensed provider, a hospital, an outpatient clinic, a Local Health Jurisdiction (LHJ), or a Community-Based Organization (CBO).
Supervising provider can provide supervision, coaching, direct support, and leadership to CHWs through training, mentoring, and case conferencing.
CHWs can be supervised by a CBO or LHJ not having a licensed provider on staff, and do not need to be the same entity as the provider who made the written recommendation for CHW services, and do not need to be physically present at the location when CHWs provide services to the CenCal Health member.

Management and day-to-day supervision of CHWs includes the following:

- Employees may be delegated as determined by the supervising provider
- However, the supervising provider is responsible for ensuring the provision of CHW services complies with all applicable requirements as described herein

- Maintain evidence of CHWs completing continuing education requirements in case of audit and may provide and/or require additional training
- Ensure CHWs meet the qualifications listed in ***the APL 22-016 (Revised) Community Health Worker Services Benefit*** and oversee the services delivered to Medi-Cal members
- Must provide direct or indirect oversight to CHWs
  - Direct includes, but is not limited to, guiding CHWs in providing services, participating in the development of a Plan of Care, and following up on the progression of their services
  - Indirect includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements
- MCP Network Providers, including Supervising Providers, are required to enroll as Medi-Cal providers if there is a state-level enrollment pathway
  - Those with a state-level Medi-Cal enrollment pathway, must follow the standard process for enrolling through the DHCS Provider Enrollment Division
- Some may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program
  - Providers must be vetted by the MCP to participate as Supervising Providers
- Credentialing requirements ***(APL 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment)*** only apply to providers with a state-level pathway for Medi-Cal enrollment

Supervising Providers without a state-level pathway are not required to meet the screening/enrollment and credentialing requirements to become "in-network."

Eligibility Criteria for services

Services are considered medically necessary for CenCal Health members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers to meeting their health or health-related social needs, and/or who would benefit from preventive services. Recommending provider shall determine whether a member meets the medical necessity criteria for CHW services based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed
- Presence of medical indicators of rising risk of chronic disease (for example, elevated blood pressure, elevated blood glucose levels, etc., that indicate risk but do not yet warrant diagnosis of a chronic condition)
- Positive Adverse Childhood Events (ACEs) screening
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse
- Results of a social drivers of health screening indicating unmet health-related social needs, such as housing or food insecurity
- One or more visits to a hospital emergency department within the previous six months
- One or more hospital inpatient stays, including stays at a psychiatric facility within the previous six months, or being at risk of institutionalization
- One or more stays at a detox facility within the previous year
- Two or more missed medical appointments within the previous six months
- Beneficiary expressed a need for support in health system navigation or resource coordination services

Authorization Requirements

CHW services require a written recommendation from a licensed practitioner. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a Network Provider in CenCal Health.

Services are recognized in 30-minute units, and the first 12 units (6 hours) are auto-approved. For requests in excess of the initial 12 units, a Treatment Authorization Request (TAR) and a written Care Plan is required and must be submitted to CenCal Health. The Care Plan must be:

- Written by one or more individual licensed providers (does not need to be the Supervising Provider);
- Clear regarding the objectives of continued CHW services to address the member's condition, including the services required; and
- Reviewed every six months.

Required Care Plan components include:

- Specify the condition that the service is being ordered for and be relevant to the condition;
- Other health care professionals providing treatment for the condition or barrier;
- Written objectives that specifically address the recipient's condition or barrier affecting their health;
- The specific services required for meeting the written objectives; and
- The frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives.

Additional information regarding the provision of CHW services can be found in CenCal Health's Community Health Worker policy, available to providers upon request.

Claims & Billing

CHW services must be reimbursed through a Supervising Provider in accordance with its provider contract, unless reimbursed directly through CenCal Health if the CHW is a Medi-Cal enrolled provider.

Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual
Must not double bill for duplicative CHW services for the same member for the same time reimbursed through other benefits such as ECM, inclusive of the services within the CHW benefit
CPT codes may be used for all services by the Supervising Provider when submitting claims, including:

- Education and training for member self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)

Maximum frequency: 4 units (2 hours) daily per beneficiary

- Additional units per day may be provided with an approved Treatment Authorization Request (TAR) for medical necessity
    - TARs may be submitted after the service was provided

Charges for the direct benefit services of the member must be billed under the member's Medi-Cal ID.

CPT Code	Session Length	Patient Numbers
98960	30 Minutes	1
98961	30 Minutes	2 - 4
98962	30 Minutes	5 - 8

In addition, the following are new allowable modifiers that may be used with these CPT codes:

Modifiers	Description
U2	Used to denote services rendered by Community Health workers
U3	Used to denote services rendered by Asthma Preventive Service providers

Reference Link:
DHCS ALL Plan Letter (APL) 22-16:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-016.pdf

Onboarding Packet
/www.cencalhealth.org/providers/join-our-network/credentialing-applications-and-forms/

Section F: Services Covered by Other Agencies

There are services offered under the Medi-Cal program for which CenCal Health does not have direct responsibility. CenCal Health may work with providers of non-covered services offered under the Medi-Cal program to ensure the coordination of care for CenCal Health members.

F1: Dental Services for Medi-Cal Members

The Medi-Cal program 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

CenCal Health has a dental liaison available to Medi-Cal dental providers to assist with referring the member to other covered services, which include but are not limited to laboratory services, pre-admission physical examinations required for admission to an outpatient surgical service center, or an inpatient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). CenCal Health may require prior authorization for medical covered services needed in support of dental procedures.

Most of these services are offered through the Medi-Cal Dental Program, not CenCal Health. If members have any questions, want to learn more about dental services or want to find a dentist in your area, call the Medi-Cal Dental Program at 1-800-322-6384 (TTY 1-800-735-2922). You may also visit the Medi-Cal Dental Program website at https://www.dental.dhcs.ca.gov or https://smilecalifornia.org/

F2: Specialty Mental Health Services

County mental health plans (MHPs) are responsible for the authorization and payment of a full continuum of specialty mental health services for CenCal Health 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 or eating disorder.
- Electroconvulsive Therapy (ECT).

Medical Necessity

To qualify for specialty mental health services, adult members (over the age of 21) must meet the County Mental Health Plan's medical necessity for services. Members can be referred to the County Access Line or CenCal Health's Behavioral Health Department for screening and referral.

CenCal Health children and youth under the age of 21 qualify for specialty mental health services under EPSDT if the services are "medically necessary."

Referral

Members can be referred to CenCal Health's Behavioral Health Department to coordinate their referral to the County Department of Behavioral Health.

Mental Health providers who are referring the member to the County Mental Health Plan should complete the DHCS-required Transition of Care tool to CenCal Health's Behavioral Health Department via fax (805) 681-3070 or the Behavioral Health Department secure link.

The DHCS required Transition of Care Tool is located on the Behavioral Health Department provider website for download.

CenCal Contact Numbers

CenCal Health Behavioral Health Department

☎ Member Line: (877) 814-1861
Provider Line: (805) 562-1600
🖷 Fax number: (805) 681-3070

Secure Link: https://gateway.cencalhealth.org/form/bh

Santa Barbara County Department of Behavioral Wellness

☎ Access Line (24/7) (888) 868-1649
Psychiatry Consultation Services: (805) 681-5103

San Luis Obispo Department of Behavioral Health

☎ Access Line (24/7) (800) 838-1381
Psychiatry Consultation Services: (805) 781-4719

F3: County Substance Use Services

Substance Use Treatment is provided by the County Alcohol and Drug Services for CenCal members who meet medical necessity. The county provides 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
- Outpatient 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.

Referral

Members who are interested may contact the Behavioral Health Department directly to coordinate their referral at (877) 814-1861 or the County Access Line

☎ Santa Barbara County Department of Behavioral Wellness
Access Line (24/7) (888) 868-1649

☎ San Luis Obispo Department of Behavioral Health
Access Line (24/7) (800) 838-1381

CenCal Health Primary Care Providers and Mental Health providers who determine a member would benefit from Substance Use Treatment Services can submit a Behavioral Health Care Coordination Referral to the Behavioral Health Department via fax (805) 681-3070, provider portal or the Behavioral Health Department secure link.

Reference Link:
Santa Barbara County Alcohol and Other Drugs Services
https://www.countyofsb.org/531/Alcohol-Other-Drugs

San Luis Obispo County
https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Drug-Alcohol-Services/Services/Drug-Medi-Cal-Outpatient-Delivery-System-(ODS).aspx

F4: Tri Counties Regional Center

Tri-Counties Regional Center (TCRC) is one of 21 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 to 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

CenCal Health Provision of Responsibilities

- CenCal Health is responsible for providing medically necessary BHT services as required by the Early and Periodic Screening, Diagnostic, and Treatment mandate, including coordination of a member's health care with the Regional Center to ensure non-duplication of services.
- CenCal Health is responsible for primary care and all other medically necessary services, including comprehensive diagnostic evaluations.
- CenCal Health and its providers must ensure that they provide care coordination and necessary member information to the Regional Center as it relates to the identification of all medically necessary services or coordination of care issues, including the development of Individual Program Plans and Individualized Family Service Plans (IFSP).

Regional Center Provision of Responsibilities

- The Regional Center shall provide Targeted Case Management (TCM) services to eligible members and their families to ensure timely access to health, developmental, social, educational, and vocational services. Targeted Case Management services include:
- Coordination of services with CenCal Health to ensure non-duplication of services.
- Provision of referrals to specialty centers and follow-up with schools, social workers, and other agencies involved with the member's care pursuant to the Individual Program Plan and the Individualized Family Service Plan (IFSP)
- Non-medical services not limited to, respite, out-of-home placement, and supportive living.

Referral

Members who are identified with conditions that are known to lead to developmental delays or those in whom a developmental delay is suspected or whose early health history places them at risk of delay may be eligible to receive services from the Early Start program and may be referred by contacting the Regional Center to request an eligibility evaluation. The Regional Center evaluation process may take up to 90 days.

Members who are identified as having a developmental disability may be referred to the Regional Center for evaluation and for access to non-medical services provided by the Regional Center.

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

Reference Link:
Tri-Counties Regional Center
https://www.tri-counties.org/

F5: Local Education Agency

A Local Education Agency (LEA) provides certain preventive, diagnostic, therapeutic, and rehabilitative services to eligible Members aged 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.
- 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 the LEA to coordinate the provision of Medically Necessary services identified on the member's IEP or IFSP.

Provision and Responsibility

- CenCal Health covers Medically Necessary services when delivered by school sites.
- CenCal provides case management and care coordination to the member, or the parent, legal guardian, or authorized representative, to ensure the provision of all Medically Necessary Covered Services identified in the IEP developed by the Local Educational Agency, with Primary Care Physician participation.

    1. 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.

CenCal Health Policy Reference:
MM-UM37 Long Term Care

F6: Medi-Cal Rx – Medi-Cal's Pharmacy Benefit

Effective January 1, 2022, Medi-Cal pharmacy benefits are administered through the Department of Health Care Services' (DHCS) Medi-Cal Rx program and not through CenCal Health.

Medi-Cal Rx is administered through DHCS and its vendor, Magellan Medicaid Administration. Magellan provides a comprehensive suite of administrative services as directed by DHCS, which include claims management/adjudication, utilization management, and customer support.

Medi-Cal Rx is 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 does not include pharmacy services billed as a medical (professional) or institutional claim. Pharmacy services, including Physician-Administered-Drugs, billed on a medical claim is 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

Reference Link:
DHCS – Medi-Cal Rx
https://medi-calrx.dhcs.ca.gov/home

CenCal Health Pharmacy Services
https://www.cencalhealth.org/providers/pharmacy/

Section G: Eligibility Verification and Enrollment

G1: Eligibility Verification and Enrollment

CenCal Health currently serves approximately 232,000 residents in our service area of Santa Barbara and San Luis Obispo counties.

The Department of Social Services (DSS) and/or each counties Social Security Administration determine SBHI and SLOHI eligibility, not CenCal Health.

CenCal Health's Member Services Department can assist with:

- 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
- Translation and Alternative Format Services
- Help creating a personal account on our member portal

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, and identify instances of member misrepresentation.

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

CenCal Health members receive an Identification Card, as shown below. The group lists the program under which the member is covered.

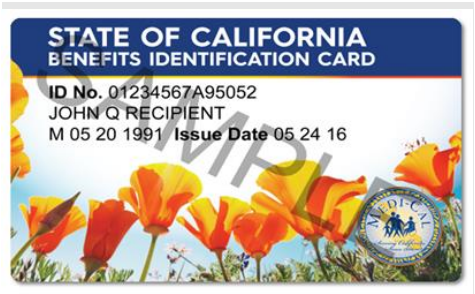
Other information printed on the card includes member name, ID number, PCP name and PCP phone number. The back of the card will also have important numbers for emergency care, after-hours care and the 24/7 Nurse Advice Line. These cards are issued only once, and are reissued only when information on 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.





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).

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.

Medi-Cal member that is not CenCal Health SBHI or SLOHI Plan

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)

Share of Cost (SOC) is a monthly dollar amount, which a patient is required to pay before they become eligible with Medi-Cal. The SOC amount is based on the income information supplied by the patient to their 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)

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.

SOC Payment

A patient can pay or make a payment plan for his/her SOC with any Medi-Cal provider.

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 their 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.

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. This means a patient's total SOC amount is paid and the provider has applied or cleared SOC with the State.

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.

State Medi-Cal Website Clearance: mcweb.apps.prd.cammis.medi-cal.ca.gov/transaction/services

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.

(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.)

Changes to a patient's SOC amount

Depending upon fluctuations in the patient's monthly income, SOC amounts may change from month to month. Additionally, if a patients' 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.

Long Term Care members with 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 an 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.

Submitting 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).

Medical & Allied Health Provider Claim details

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

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

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

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".

Section I: Care Management Programs and Community Support Services

I1: Utilization Management

CenCal Health maintains a Utilization Management (UM) Program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered services for members. "The UM program will be consistent and in accordance with DHCS guidelines (APL 21-011, *Grievance and Appeal Requirements, Notice and "Your Rights" Templates*; and the *H&S Code 1367.01*) The Chief Medical Officer, Medical Directors, and qualified licensed healthcare professionals are responsible for the utilization review process.

CenCal Health's Utilization Management Program helps members to get the best quality healthcare by assuring that medically necessary services are provided at the right time and at the most appropriate service level or care setting covered under their benefit package. UM staff work with providers to evaluate services for medical appropriateness and timeliness.

- Authorization decisions are made on Medical Necessity of a requested health care services and are consistent with criteria or guidelines supported by clinical principles that are evidenced based.
- UM does not pay, offer financial incentives, or reward providers, employees or other individuals for utilization management decisions.
- UM's policies and procedures related to authorization reviews are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
- CenCal Health makes all relevant Utilization Management policies and procedures available upon request.
- UM activities are integrated into the Quality Improvement Systems to review requests, denials, deferrals, modifications, appeals and grievances to the medical director.
- CenCal Health maintains timelines and process that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Limitations (NQTL) more stringently in mental health or substance use disorder services than are imposed on medical/surgical services.

I2: Enhanced Care Management

Effective July 1, 2022, CenCal Health offers Enhanced Care Management (ECM) a new statewide Medi-Cal benefit available to selected "Populations of Focus" as part of CalAIMs multi year initiatives. ECM is designed to address the clinical and non-clinical needs of the highest-need Members through intensive whole person care coordination. ECM has a phased implementation approach based on Department of Health Care Services defined Populations of Focus (POF).

Phase 1: 7/1/2022

- Individuals & Families Experiencing Homelessness (POF 1)
- Adults At Risk for Avoidable Hospital and Emergency Department (ED) Utilization(POF 2)
- Adults with SMI/SUD Needs (POF 3)

Phase 2: 1/1/2023

- Adults Living in the Community At Risk for Institutionalization (POF 5)
- Adults who are Nursing Facility Residents Transitioning to the Community (POF 6)

Phase 3: 7/1/2023

Children & Youth Populations of Focus

- Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness (POF 1)
- Children and Youth At Risk for Avoidable Hospital or ED Utilization (POF 2)
- Children and Youth with Serious Mental Health and/or SUD Needs (POF 3)
- Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition (POF 7)
- Children and Youth Involved in Child Welfare (POF 8)
- Children and Youth with Intellectual/Developmental Disability (I/DD) (POF 9)
- Pregnant or Postpartum Youth (POF 10)

Phase 4: 1/1/2024

- Individuals Transitioning from Incarceration (POF 4)
- Birth Equity Population of Focus (Adults and Youth) (POF 10)

ECM has been available for adults with intellectual or developmental disabilities (I/DD) and Pregnant and Postpartum from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus.

Members who are eligible for ECM are assigned to an ECM provider who has the expertise in serving the various populations of focus and will provide Outreach to engage member to enroll in the program. Members who agree to participate in ECM will be assigned a Lead Care Manager who will meet the member wherever they are (e.g., Street, Shelter, Skilled Nursing Facility) and who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for Members to get the right care at the right time.

The ECM provider will offer the following seven (7) ECM core components

- Outreach and Engagement
- Comprehensive Assessment and Care Management Planning
- Enhanced Coordination of Care
- Health Promotion Activities
- Comprehensive Transitional Care Planning
- Member and Family Supports
- Coordination of and Referral to Community and Support Services

Primary Care Providers (PCP) are an integral part of the member's care coordination team and will be notified when an ECM eligible member has been enrolled in the ECM program. The notification will include name and contact information of the member's assigned ECM provider.

Referring Members to Enhanced Care Management

Providers are welcome to refer members who may benefit from ECM. ECM Referrals can also be submitted by but not limited to members or their Authorized Representatives, Community and Government agencies. To submit a referral request for ECM or to learn more about the Population of Focus criteria, Click here, or call our Member Services Department at 1-877814-1861. We ask that you please allow ten (10) business days to determine eligibility and assign an ECM provider for Member Outreach.

To learn more about ECM please click here www.cencalhealth.org/providers/calaim/

CenCal Health Policy Reference:
MM-CM121 Enhanced Case Management (ECM)

I3: Care Management (Complex and Care Coordination)

CenCal Health's care management programs support members with the appropriate level of care management through person-centered interventions and individualized care plans based on the intensity of health and social needs and services required. Assessments are completed to ensure members who are identified as having medical, behavioral, oral, Long Term Services and Supports and social determinants of health needs receive the necessary services to gain optimum health.

CenCal Health has five variations of care management and care coordination services:

- Enhanced Care Management (ECM)
- Case Management (Complex and Care Coordination)
- Care Transitions
- Pediatric Whole Child Program
- Disease Management Program

Each of the Care management services promote quality care and cost-effective outcomes that enhance physical, psychosocial, and vocational heath of individuals. It includes on going assessing of needs, planning, implementing, coordinating, and evaluating health-related service options. Members may self-refer to the Care Management programs. Referrals 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 learn more about ECM please see the Enhanced Care Management Section I2.

To refer a member to any of our Care Management Programs, providers can complete and submit a Case Management Referral Form located at www.cencalhealth.org. The completed 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).

Reference Link:
Case Management Referral Form
https://www.cencalhealth.org/providers/case-management/

Care Management

CenCal Health Care Management ensure that the needs of member are met across the continuum of care. Members are provided appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. Coordination of care is done collaboratively with member and their PCP, specialists and other members of the interdisciplinary team. Coordination of care also includes coordinating health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of CenCal Health's Provider Network, and with Community Supports and other community-based resources, even if they are not Covered Services under CenCal Health , to address Members' needs and to mitigate impacts of Social Determinants of Health .

Referrals to Care Management

Members may be eligible for Care management Services if they meet one of the following criteria:

- 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, Drug Medi-Cal Organization Delivery System 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).
- Or, if a member's estimated health risk is high based on the integration of utilization-based and/or non-utilization-based member attributes that, upon CenCal Health Case Management team's verification, indicate a need for Case Management support.

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

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 Care 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 Care Manager will work with Providers to assess, plan and monitor options and services for members with chronic illness or injury.

CenCal Health Policy Reference:
MM-CM114 Care Management Program Planning and Coordination

Reference Links:
DHCS All Plan Letter (APL 23-018, *Managed Care Health Plan Transition Policy Guide*).
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-018.pdf

I4: Care Transitions

CenCal Health provides Transitional Care Services (TCS) to Members transferring to one setting, or level of care, to another. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities to home or community-based settings, Community Supports (e.g. Recuperative Care), post-acute care facilities or Long-Term Care settings. The goal of this program is to improve transitions of care for our members by improving quality of care and avoid preventable readmissions.

The Transitional Care team will collaborate with the facility staff and/or Member family/caregiver to facilitate the transition of care and ensure members identified as high risk per the CalAIM: population Health Management (PHM) Policy Guide criteria, are receiving care at the right setting and will receive the necessary services upon discharge. Transitional Care Services includes:

A. Completion of a discharge risk assessment to evaluate a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition, and/or SUD relapse.
B. Completion of a discharge planning document
C. Medication reconciliation
D. Post-discharge services and follow-up for PCP/ambulatory appointments.
E. Linkage if needed to longer-term care coordination services, such as Enhanced Care Management, Complex Care Management, and Community Supports etc.

CenCal Health Policy Reference:
HS-MM44 Transitional Care Policy

Reference Links:
DHCS All Plan Letter (APL 21-005, *California Children's Services Whole Child Model Program*)
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-005.pdf

I5: Pediatric Whole Child Model

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. Like 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 management and 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
- Transition Planning to adulthood

Providers can refer a child or youth under the age of 21 to the Pediatric Whole Child Program care management team by completing a CM Referral Form which can be found at www.cencalhealth.org, under the Provider tab. Authorization requests (50-1, 18-1, 20-1) and referrals (RAF) be submitted via the Provider Portal.

CenCal Health Policy Reference:
MM-CM14 Program Planning and Coordination

I6: Community Supports

Community Supports are medically appropriate and cost-effective alternative services. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations. Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible members.

Community Supports are optional services for CenCal Health to offer and are optional for members to receive. As of January 1, 2024, CenCal Health has elected to offer the following Community Supports:

• Housing Transition Navigation Services
• Housing Deposits
• Housing Tenancy and Sustaining Services
• Medically Tailored Meals
• Sobering Center
• Recuperative Care
• Short-term Post Hospitalization Housing
• Day Habilitation
• Respite Services Personal Care and Homemaker Services

Supportive Services

Community Supports will typically be provided by community-based organizations and providers. ECM Providers may also serve as Community Supports Providers, if they have appropriate experience.

Members Eligible to Receive Community Supports

CenCal Health must determine eligibility for a pre-approved Community Supports using the DHCS Community Supports definitions, which contain specific eligibility criteria for each Community Supports. CenCal Health is also expected to determine that a Community Supports is a medically appropriate and cost-effective alternative to a Medi-Cal Covered Service. When making such determinations, CenCal Health must apply a consistent methodology to all members within a particular county.

Making a Referral for Community Supports

Referrals for Community Supports may be made by a physician, an CenCal Health member or their caregiver, community service agency, hospital or health care provider, or an ECM or Community Supports provider. Community Support Information and Referral Forms are on CenCal Health's website.

Community Supports Authorizations

Authorization through CenCal Health is required for members to obtain Community Supports. CenCal Health staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to determine eligibility. The authorization process entails eligibility screening, the required Information and Referral form associated to that specific Community Supports service,
completion of a Member Care Plan by the ECM Provider (if receiving ECM services), and decision-making by CenCal Health. If approved after CenCal Health's assessment, the member may receive Community Supports. Some Community Supports, such as housing deposits, are limited to once per lifetime.

Utilization management procedures will consider the goals of each Community Supports and CenCal Health will not categorically deny or discontinue a Community Supports irrespective of member outcomes or circumstance. Some Community Supports will require periodic reauthorization by submitting an Authorization Request to the Utilization Management Department, along with any necessary documentation for review. Documentation for the reauthorization may be submitted through the Provider Portal.

CenCal Health Policy Reference:
HS-MM23 Recuperative Care
HS-MM24 Medically Tailored Meals Program
HS-MM25 Housing Transition Navigation Services
HS-MM26 Housing Deposits
HS-MM27 Housing Tenancy and Sustaining Services
HS-MM28 Sobering Centers

Reference Links:
DHCS APL 21-017 Community Supports Requirements
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-017.pdf

Section J: Disease Management Programs

J1: Disease Management Programs Addressing Chronic Diseases

CenCal Health's Disease Management Program (DMP)and services are aligned with NCQA requirements. Using a proactive, multidisciplinary, and systematic approach, CenCal Health's DMPs partner the primary care provider (PCPs) as the primary manager of the member's care supported by plan staff and specialists.

At minimum, the programs and services address the following health conditions:

- Asthma
- Cardiovascular disease
- Diabetes
- Depression
- Maternal mental health

Members with any of these conditions receive care coordination services and support from CenCal Health that is appropriate for their medical circumstances, and compliant with NCQA's standards for PHM Complex Case Management.

- CenCal Health additionally provides targeted disease management interventions and support for Members with Diagnosis of diabetes mellitus or heart disease with recent ED visit or hospital admission

All programs provide a comprehensive, ongoing, and coordinated approach to achieving desired health outcomes and seek to close care gaps for members participating in the interventions to improve health equity and reduce health disparities.

CenCal Health disease management programs help facilitate patient's care, and 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

If you want to refer a new patient or confirm a patient is in the program call CenCal Health Case Management Department (805)562-1082.

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, you may contact our Claims Customer Service Representatives. 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 clearinghouse, via our Website at www.cencalhealth.org, or on a hard copy claim form.
- "Clean" claims will be processed 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 number(s), 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, 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), correct the issue(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.

Claims received after 6 months from initial Explanation of Payment date or month in which services were rendered are subject to payment reduction.

Prohibited Claims

CenCal Health, its Providers, subcontractors, and downstream subcontractors are required to comply with 22 CCR sections 53866, 53220, and 53222 with regard to the submission and recovery of claims for Medi-Cal covered services.

CenCal Health, its Providers, subcontractors, and downstream subcontractors shall not submit a claim to, demand, or otherwise collect reimbursement from, a Member or persons acting on behalf of a Member for any Medi-Cal Covered Services except to collect third-party payment in accordance with 22 CCR section 53222(a), or payment for non-covered services provided pursuant to 22 CCR section 53210(d). Even in the event of CenCal Health's failure to pay for Covered Services, Providers, subcontractors, and downstream subcontractors are prohibited from billing or attempting to collect from Members (other than copayments) and shall hold harmless the Members and the State.

Recovery from third party sources for Medi-Cal Covered Services rendered to a Member may be allowed, to the extent that such Member is covered for such services under any other state or federal medical care program or under other contractual or legal entitlement, including but not limited to, a private group or individual indemnification program. However, recovery shall not be attempted in circumstances involving casualty insurance, tort liability or worker's compensation. Circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation awards shall be reported to DHCS within ten days after discovery.

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 Claim 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

Email Inquiries:

CencalClaims@Cencalhealth.org

CenCal Health Policy Reference:
FIN-FA - 04 Prohibited Claims

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 and supportive documentation.

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 of the Provider Manual.

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

Other Health Coverage (OHC) refers to private health insurance. Services may include medical, dental, vision, pharmacy, and/or Medicare supplemental plans (Part C & D).A person covered under CenCal Health may also have other private/group health insurance. Having private/group health insurance does not affect a member's 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 CenCal Health but not the member's PCP through Blue Cross HMO, you should refer the member to their 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 their HMO and/or ask the member to contact the CenCal Health Member Services Department to reselect a PCP who participates in both programs.

Federal and state laws require Medi-Cal beneficiaries to report OHC to ensure Medi-Cal is the payer of last resort. Which means in most cases Medi-Cal will be secondary to the OHC, covering allowable costs not paid by the primary insurance up to the Medi-Cal rate. When Medi-Cal learns that a beneficiary has OHC, the Medi-Cal record is than updated to reflect the OHC.

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 CenCal Health. 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. A list of services that can be billed directly to CenCal Health can be found in the Medi-Cal manual section under Other Health Coverage (OHC): CPT and HCPCS Codes
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.

Locating Recipient's OHC Information:
The Medi-Cal eligibility verification system returns a message that includes OHC information, when known. The eligibility verification system is accessed through the Automated Eligibility Verification System (AEVS) Medi-Cal website at www.medical.ca.gov

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.

CenCal Health will reimburse the provider up to the Medi-Cal allowable, less the other health coverage payment amount but will not exceed the member's coinsurance amount. CenCal Health will not pay the balance of a provider's bill when the provider has an agreement with the other health coverage to accept its contracted rate as "payment in full".

If the recipient elects to seek services not covered by CenCal Health, CenCal Health is not liable for the cost of those services.

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. CenCal Health will not pay for the services if the patient elects to go to a provider who is non-participating with the primary plan for care. However, CenCal Health 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 may not be 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 section under "medi non cpt" and "medi non hcp." CenCal Health may reimburse providers for the Medicare deductible and coinsurance. A claim for Medicare deductible and coinsurance amounts is called a crossover claim.

Medicare uses a consolidated Coordination of Benefits Contractor (COBC) to automatically cross over to Medi-Cal for claims billed to any Medicare contractor for Medicare/Medi-Cal eligible recipients. Note: Providers do not need to rebill to Medi-Cal for claims that automatically cross over.

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 CenCal Health. 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.

Claims submitted to Medicare electronically will automatically crossover to CenCal Health for processing. These claims should appear on your EOP within 45 working days. If your claim has not appeared on an EOP within this timeframe, you can submit your claims via the portal or electronically through your EDI clearing- house. For further assistance please contact your Claims Service Representative at 805-562-1083.
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.

Reference Link:
Medicare Non-Covered Services: CPT Codes
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/6B724B76-FE3C-4C5D-9F16-44301101CD64/medinoncpt.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

Medicare Non-Covered Services: HCPCS Codes

https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/E18FD10B-3F5D-4610-902E-9106A3DF2591/medinonhcp.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

K7: Recoveries of Overpayments to Providers

Per APL 23-011 - Each MCP must require, and have a mechanism for, Network Providers to report to the MCP when they have received an overpayment, to return the overpayment to the MCP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCP in writing of the reason for the overpayment.

Providers may report any overpayments in one of the following ways:

- Email: Recoveries Department recoveries@cencalhealth.org
- Fax: (805) 681-3077
- Mail: CenCal Health, Attn: Recoveries Department, 4050 Calle Real, Santa Barbara CA 93110

Providers must include the following claim information on any overpayment communication to ensure accurate identification and application of funds:

- CCN – Claim Number
- Date of Service
- Member ID#
- Refund reason
    - Any associated backup documents

Reference Link:
Department of Health Care Services APL 23-011
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-011.pdf

Section L: Quality Management

L1: Quality Improvement System

CenCal Health is firmly committed to high-quality equitable care delivered to our membership in a timely, appropriate, and compassionate manner. The way we ensure this happens is through our Quality Improvement and Health Equity Transformation Program (QIHETP). This program was designed to support CenCal Health's vision *to be a trusted leader in advancing health equity so that our communities thrive and achieve optimal health together*. The Quality Improvement System aligns with state regulations, (28 CCR 1300.70., Health Care Service Plan Quality Assurance Program). Additionally, the Quality Assurance for UM program oversight is consistent with DHCS guidelines (APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates) and the state regulations (H&S Code 1367.01).

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.

CenCal Health network providers and practitioners shall cooperate with CenCal Health's quality improvement activities to improve the quality of care and services, patient safety, and member experience. Cooperation includes collection and evaluation of data, including performance measurement data, and participation in CenCal Health's QIHETP. Network providers and practitioners agree that CenCal Health may use their performance data for quality improvement activities.

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 Improvement and Health Equity Transformation Program Work Plan and Evaluation of the prior year are developed annually in congruence with CenCal Health's Quality Improvement and Health Equity Transformation Program Description and CenCal Health's Strategic Plan.

- An annual Evaluation 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 to prospectively refine CenCal Health's Quality Improvement System.
- The annual Work Plan serves as a roadmap of specific quality improvement and health equity objectives and it establishes staff accountability for key activities in the coming year. To assure successful quality performance, with the annual development of CenCal Health's Work Plan, CenCal Health's leadership sets appropriate goals and objectives for staff.

For additional information, please contact CenCal Health's Population Health staff at populationhealth@cencalhealth.org.

Reference Link:
CenCal Health's Quality Improvement and Health Equity Transformation Program
www.cencalhealth.org/providers/quality-of-care/quality-program/

CenCal Health's Quality Improvement and Health Equity Committee Quarterly Reports to CenCal Health's Board of Directors
www.cencalhealth.org/providers/quality-of-care/quarterly-reports/

L2: Quality of Care 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 (PQIs) and initiate corrective action when appropriate. This helps to continually improve the quality of care delivered to our members.

PQI sources include:

- Member originated:
    - 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.
- External Referral (not member originated)
    - CenCal Health's contracted providers, community agencies, and liaisons (CCS, APS, hospital case managers) may email concerns to PQI@cencalhealth.org.
- Internal Referral
    - Any of CenCal Health's staff may identify PQIs and email them to PQI@cencalhealth.org.

Review Process

The assigned PQI 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 practitioner chart notes, Emergency Department records, pharmacy profile, and a response from the practitioner when appropriate.
- Additional review or a focused site review may be required if the medical records, pharmacy, or claims review are insufficient to answer all clinical concerns.
- CenCal Health's Chief Medical Officer (CMO) or 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 CMO or Physician Designee will consult with expert clinical specialists if applicable.
- If a deviation from standard of care is suspected, the CMO or Physician Designee will contact the practitioner involved to discuss the concern directly. Formal practitioner interaction may be undertaken to complete the investigation and assure due process as indicated.
- The CMO or Physician Designee 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 practitioner directly 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 practitioners 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 Improvement and Health Equity Transformation Program (QIHETP) Description, including:

- Utilization and care management programs
- Managed Care Accountability Set (MCAS) data collection - *refer to section L5 - Performance Monitoring for more details.*
- Plan-Do-Study-Act (PDSA)
- Performance Improvement Projects
- Other quality improvement and health equity activities, policies, or processes

These activities are in accordance with DHCS All Plan Letter (APL) 19-017 to identify improvements in quality of care for our membership to monitor, evaluate, and address accordingly.

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 Improvement and Health Equity Committee (QIHEC) 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 or QMGRP@cencalhealth.org

Reference Link:
Department of Health Care Services All Plan Letter (APL) 19-017
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-017.pdf

L4: Quality Care Incentive Program

The Quality Care Incentive Program (QCIP) 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. This innovative program encourages increased utilization of evidence-based treatment, screening, and preventive health services.

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. Performance is measured against pre-defined, industry-standard, clinical measures. Measurement results are calculated using NCQA-certified HEDIS reporting software.

Measures:
Categories and measures are systematically identified for inclusion in the program based on the following criteria:

- Clinical importance for CenCal Health's members
- Areas of needed quality improvement for CenCal Health
- Feasibility of accurate 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

Categories and measures are evaluated annually to ensure that the above criteria are met. As priorities 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 performance is calculated as a percentage, based on the numerator divided by the denominator, for each qualifying measure.

- Overall performance is based on the sum of all measure numerators divided by the sum of all measure denominators 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 after it is rounded up to 2 decimal places 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
- Incentive payments will be completed quarterly reflecting performance through the end of the prior month, 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 an incentive payment at the time of quarterly payment calculations. In lieu of an earned QCIP incentive, PCPs that do not qualify receive payment equal to the capitation withhold that they did not have opportunity to earn.

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 are clinically significant 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 *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.

Performance Reporting

Performance reporting occurs monthly for all PCPs and made available via the Provider Portal on CenCal Health's website, www.cencalhealth.org, in the Quality Care Incentive Program module. Reporting is broken up into three (3) sections:

- QCIP Dashboard
- QCIP Performance Overview
- QCIP Financial Overview

For detailed instructions regarding navigation of the Provider Portal screens, please refer to cencalhealth.org/providers/provider-training-resources

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.

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 (incentivized measure have an asterisk*)
    - County of service
    - Time frame
- The PCP's quality performance score by month is reflected on the trend line and performance rates can by 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 QCIP Provider Summary Detail screen. It includes:
        - Number of members in each measure category
        - Number of members in each measure category that received the target services
            - By clicking on the number in this field you can drill into member detail
        - Number of members in each measure category that did not receive the target services
            - 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 members in each measure that received targeted services
            - By clicking on the number in this field you can drill into member detail
        - Number of members in each measure that did not receive targeted services
            - 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 members in the program that received targeted services
            - By clicking on the number in this field you can drill into member detail

        - Number of overall members in the program that did not receive targeted services
            - By clicking on the number in this field you can drill into member detail
        - Overall program rate
    - All member detail includes: 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.

Financial Overview

The Quality Care Incentive Program Financial Overview displays each PCP's trended incentive payments and the trended incentive funding available to them. It includes:

- Trended financial payments performance which can be filtered by:
    - PCP Location as applicable
    - Time frame
- Financial payment performance by quarter is reflected on the trend line, and payment amounts can by displayed by hovering over the trend line marker. Projected monthly earnings and available funding is also displayed on a separate trend line.
    - Each trend line marker can be clicked on to display the quarterly or the monthly (projected) payment detail on the QCIP Payment Scoring Detail screen.
    - QCIP 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

Provider Ranking

The Quality Care Incentive Program Monthly Provider Ranking Report displays the providers star ranking in descending order by their performance score.

- The ranking report can be filtered by:
    - Time frame

- Quality Care Incentive Program Monthly Provider Ranking Report includes:
    - Provider Name
    - Star Ranking
    - Performance score
    - Earning %

Program Support

CenCal Health's Population Health and Provider Relations Departments are available to provide orientation regarding quality measures, strategies to maximize data reporting, and sharing of best practices to help maximize service utilization consistent with prevailing evidence-based treatment and preventive health guidelines. Contact QCIP@cencalhealth.org for additional support.

Reference Link:

CenCal Heath Quality Care Incentive Program

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) and the Department of Health Care Services (DHCS). CenCal Health shares CMS' and DHCS' 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 (HEDIS) is the primary tool used by CenCal Health to measure the quality of health care provided to our members. Developed by the National Committee for Quality Assurance (NCQA), HEDIS[1] provides a standardized methodology that is used nationally by health plans and regulators to evaluate important aspects of care.

Because of the excellent health care 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.

Medi-Cal Managed Care Accountability Set (MCAS)

DHCS annually compiles a list of performance measures called the Medi-Cal Managed Care Accountability Set (MCAS) and requires all Medi-Cal plans to report on these priorities.

The MCAS list for Measurement Year (MY) 2024/Reporting Year (RY) 2025 consists of 39 performance measures.

The NCQA Medicaid 50th percentile is the minimum performance level (MPL) set for 20 of these performance measures. CenCal Health is subject to financial sanctions, quality improvement plans, and/or corrective action for performance that fails to meet or exceed any DHCS MPL.

Note: To find the current measurement year's performance measures, CenCal Health shares this information via CenCal Health's Website, Provider Bulletin, and Provider E-Mail Blast.

Please find the comprehensive list of the MY 2024/ RY 2025 draft MCAS measures that are currently available at the time of this publication:

#	MEASURE NAME	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY**	HELD TO MPL
	Behavioral Health Domain			
1	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	YES
2	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	YES
3	Pharmacotherapy for Opioid Use Disorder*	POD	Administrative	YES
	Cancer Prevention Domain			
4	Breast Cancer Screening*	BCS-E	ECDS	YES
5	Cervical Cancer Screening	CCS	Hybrid	YES
6	Colorectal Cancer Screening*	COL-E	ECDS	YES
	Children's Health Domain			
7	Child and Adolescent Well-Care Visits*	WCV	Administrative	YES
8	Childhood Immunization Status: Combination 10*	CIS-10	Hybrid	YES
9	Developmental Screening in the First Three Years of Life	DEV	Administrative	YES
10	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid	YES
11	Lead Screening in Children	LSC	Hybrid	YES
12	Topical Fluoride for Children	TFL-CH	Administrative	YES
13	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	Administrative	YES
14	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	W30-2+	Administrative	YES
	Chronic Disease Management Domain			
15	Asthma Medication Ratio*	AMR	Administrative	YES
16	Controlling High Blood Pressure*	CBP	Hybrid	YES
17	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (> 9%) *	HBD	Hybrid	YES
	Reproductive Health Domain			
18	Chlamydia Screening in Women	CHL	Administrative	YES
19	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid	YES
20	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid	YES
	Report Only Measures to DHCS			
21	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	NO
22	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-Init	Administrative	NO
23	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	NO
24	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	NO
25	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	NO
26	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	NO
27	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	NO
28	Depression Screening and Follow-Up for Adolescents and Adults*	DSF-E	ECDS	NO

29	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	NO
30	Follow-Up After ED Visit for Substance Use – 7 days*	FUA	Administrative	NO
31	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	NO
32	Plan All-Cause Readmissions*	PCR	Administrative	NO
33	Postpartum Depression Screening and Follow Up	PDS-E	ECDS	NO
34	Prenatal Depression Screening and Follow Up	PND-E	ECDS	NO
35	Prenatal Immunization Status	PRS-E	ECDS	NO
36	Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications	SSD	Administrative	NO
LTC Report Only Measures to DHCS				
37	Number of Outpatient ED Visits per 1,000 Long Stay Resident Days*	HFS	Administrative	NO
38	Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization*	SNF HAI	Administrative	NO
39	Potentially Preventable 30-Day Post Discharge Readmission*	PPR	Administrative	NO

* Measures that will be stratified by race/ethnicity to identify health disparities.

** Methodology Explanation:

- **Administrative:** Measure compliance via Claims, Pharmacy, Immunization Registry, and Supplemental Data
- **Hybrid:** Measure compliance via Administrative, plus medical record review
- **ECDS (Electronic Clinical Data Systems):** Measure compliance via Administrative, plus data from an Electronic Medical Record, Health Information Exchange (HIE)/Clinical Registry, and Case Management System

For questions regarding measurement specifications, please contact CenCal Health's Quality Measurement team at (805) 562-1609 or QMGRP@cencalhealth.org.

Medical Record Review and Reporting Process

CenCal Health begins its quality of care reviews every year in January, which includes several steps performed in strict accordance with HEDIS[1] 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 DHCS and NCQA.

Remote Electronic Medical Record (EMR) System Access

Remote medical record review via secure connection to providers 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 team at (805) 562-1609 or QMGRP@cencalhealth.org.

HIPAA

All providers are contractually obligated to provide CenCal Health with medical records upon request without the need for member consent. HEDIS data collection and release of information are permitted under HIPAA since the disclosure of records is part of quality assessment and improvement activities. Please be assured that when providing Quality staff EHR access, or medical records via a different means, that protected health information is maintained in accordance with federal and state laws.

Reference Links:

CenCal Health Performance Measures
https://www.cencalhealth.org/providers/quality-of-care/performance-measures/

Medi-Cal Managed Care Accountability Set
https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx#:~:text=The%20Managed%20Care%20Accountability%20Sets%20%28MCAS%29%2C%20previously%20known,reporting%20by%20Medi-Cal%20managed%20care%20health%20plans%20%28MCPs%29.

L6: Performance Improvement Projects

Performance Improvement Projects (PIPs) are rapid cycle quality improvement projects used to enhance quality and improve healthcare outcomes through process improvements over an extended period. The California Department of Healthcare Services (DHCS) requires all Medi-Cal Managed Care Plans to participate in a minimum of two (2) PIPs per cycle. These PIPs must be reported to DHCS' designated External Quality Review Organization (EQRO).

PIP Topics are selected in consultation with DHCS and must align with demonstrated areas of poor performance, such as low scores for measures within the Managed Care Accountability Set which includes National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS) measures. Topic selection can also be based on low CAHPS®[1] scores and/or DHCS/EQRO recommendations. PIPs 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.

CenCal Health may ask providers in our contracted network to participate in these PIPs. Participation consideration is based on the requirements of the PIP as well as the providers scores as they relate to scores related to the topic selection.

CenCal Health's PIPs for 2023-2026:

- Improve the percentage of provider notifications for CenCal Health members diagnosed with substance use disorder (SUD) or serious mental illness (SMH) diagnoses within 7 days of an emergency department (ED) visit.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- Improve Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits (W30–6) measure rates for CenCal Health's Hispanic/ Latino population and decrease the disparity among other racial/ethnic counterparts.

L7: Initial Health Appointments

Primary Care Providers (PCPs) are required to perform an Initial Health Appointment (IHA) for each newly assigned member **within 120 days** of assignment. For members less than 18 months of age, PCPs must ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

Initial Health Appointment's enable PCPs to comprehensively assess and manage a member's current acute, chronic, and preventive health needs, and identify whose health needs require coordination with appropriate community resources and/or other agencies.

Note: An IHA is not necessary if the member's medical record contains complete and current information updated within the previous 12 months to allow for assessment of the member's health status and health risk.

Initial Health Appointment Components: Documentation of the following components must be available in the medical record and provided in a way that is culturally and linguistically appropriate:

- Comprehensive history of physical and behavioral health status including past and social history as well as a review of organ systems
- Current physical and behavioral health examination
- Perinatal Services (when applicable)
- Oral health assessment and dental screening and referral for children
- Assessment for age/gender specific preventive screenings or services and health education
- Preventive screening as recommended by the United States Preventive Services Taskforce (USPSTF), Grade A & B recommendations
    - *Not all Grade A & B recommendations have to be completed during the IHA, so long as members receive all required screenings in a timely manner consistent with USPSTF guidelines.*
- Identification of risks (e.g., drug, alcohol, or tobacco use)
- Health education and anticipatory guidance appropriate for age
- Diagnosis and plan for treatment of any diseases

In addition to the components described above, IHAs must be completed in accordance with:

- Early and Periodic Screening, Diagnostic and Treatment American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule for *members under age 21, including but not limited to provision of all immunizations necessary to ensure that members are up-to-date for their age, Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings.*
- American College of Obstetricians and Gynecologists (ACOG) standards and guidelines for *pregnant or postpartum members*

For pregnant, breastfeeding, or postpartum members, or a parent/guardian of a child under the age of five (5), documentation of a referral to the Women, Infants, and Children Program (WIC) program is mandated by Title 42 CFR 431.635(c).

As soon as possible and no later than 60 calendar days following the IHA or other visit that identified a need for follow-up, 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

immunizations in accordance with the recommendations published by the Advisory Committee on Immunization Practices (ACIP).

If any component of the IHA is refused, the member's, or parent's or guardian's, voluntary refusal must be documented in the member's medical record to indicate the services were advised.

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: CenCal Health's new Quality Care Incentive Program encourages IHA visits through measures like Well Child Visits in the First Thirty Months of Life, Child and Adolescent Well-Care Visits, HbA1c Testing, Breast Cancer Screening, and Cervical Cancer Screening.

Monitoring: To assure the completion and documentation of required components addressed during an IHA visit, CenCal Health performs medical record audits. Findings are shared via IHA Provider Performance Reports and discussed with audited PCPs. The completion of IHA documentation is also monitored through the Facility Site Review process.

Member Outreach: CenCal Health performs 3 documented attempts (telephone and mail notification) to inform new members that an IHA is a covered benefit. Members are instructed to call their PCP for an appointment to assure their health care risks and needs are assessed and met timely.

Billing: PCPs should use the following codes when billing for IHAs:

Member Population	CPT Billing Codes	ICD-10 Codes
Preventive visit, new patient	99381 - 99387	No restriction
Preventive visit, established patient	99391 - 99397	No restriction
Office visit	Any CPT and appropriate diagnosis code: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5, Z76.1, Z76.2	
Obstetrical Care	Z1032, Z1034, Z1038, Z6500, 59400, 59510, 59610, 59618	Prenatal/Postpartum related diagnosis

Reference Links:

USPSTF Grade A & B Recommendations
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

Bright Futures/AAP Periodicity Schedule
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.40438369.2145994991.1677151637-1437524156.1677151636

American College of Obstetricians and Gynecologists (ACOG) standards and guidelines
https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline

Advisory Committee on Immunization Practices (ACIP)
https://www.cdc.gov/vaccines/acip/recommendations.html

Department of Health Care Services All Plan Letter (APL) 22 – 030:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf

CenCal Health's Quality Care Incentive Program
https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

L8: Adverse Childhood Experiences Screening

An Adverse Childhood Experiences (ACEs) screening evaluates children and adults for trauma that occurred during the first 18 years of life.

Training and Certification

The California Department of Health Care Services (DHCS), in partnership with the California Office of the Surgeon General, created a first-in-the-nation statewide effort to screen patients for ACEs that lead to trauma and the increased likelihood of ACEs-Associated-Health Conditions due to toxic stress.

Detecting ACEs early and connecting patients to interventions, resources, and other supports can improve the health and well-being of individuals and families. By screening, providers can better determine the likelihood a patient is at increased health risk due to a toxic stress response, which can inform patient treatment and encourage the use of trauma-informed care.

The two-hour online curriculum will provide Continuing Medical Education (CME) and Maintenance of Certification (MOC) credits. To sign up, go to: https://www.acesaware.org/

Please make a copy of your email confirmation, and email a copy of your training certificate to CenCal Health Provider Relations Department at psrgroup@cencalhealth.org.

Billing and Payment

To be eligible for reimbursement, the network provider performing the screening must meet all the following criteria:

1. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate.
2. Be on DHCS' list of providers that have completed the state-sponsored trauma-informed care training and provided a *self-attestation*.
3. Bill using one of the HCPCS codes in the table below.

Patients under age 21 may receive periodic rescreening as determined appropriate and medically necessary, not more than once per year, per provider. Patients age 21 and older may be screened once in their adult lifetime up to age 65, per provider.

Coding of the screening is dependent on the resulting score.

HCPCS Code	Description	ACEs Score
G9919	Screening performed – results *positive* and provisions of recommendations provided	4 and greater (high risk)
G9920	Screening performed – results *negative*	0 to 3 (low risk)

Screening Tools

The ACEs questionnaire for adults (ages 18 years and older) and Pediatric ACEs and Related Life-events Screener (PEARLS) tools for children (ages 0 to 19 years) are both forms of ACEs screening. Both tools are acceptable for members aged 18 or 19 years. The ACEs screening portion (Part 1) of the PEARLS tool is also valid for use to conduct ACEs screenings among adults ages 20 years and older. If an alternative version of the ACEs questionnaire for adults is used, it must contain questions on the 10 original categories of ACEs to qualify.

10 original ACE categories:

- Abuse
    1. Physical
    2. Emotional

3. Sexual

- Neglect
    4. Physical
    5. Emotional
- Household Dysfunction
    6. Parental incarceration
    7. Mental illness
    8. Substance dependence
    9. Separation or divorce
    10. Intimate partner violence

The ACEs questionnaire and the PEARLS tool are available at the following link:
https://www.acesaware.org/screen/screening-for-adverse-childhood-experiences/

Documentation Requirements

Medical record documentation of the ACEs screening must remain in the patient's medical record and be available upon request. It must include:

- Use of appropriate screening tool
- Review of completed screening
- Results
- Interpretation of results
- Discussion with the patient and/or family
- Any appropriate actions taken

Information, materials, screening tools, and training opportunities can be found at ACEsAware.org, or by emailing info@ACEsAware.org. For more information on this service, or for help improving your clinical care, please email CenCal Health's Quality team at qualityimprovement@cencalhealth.org.

L9: Social Determinants of Health (SDOH)

Social Determinants of Health (SDOH) are conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Consistent and reliable collection of SDOH data is vital to identify ways to support our members.

There are several health-related social factors that can be improved through the analysis of the member characteristics, health, social, and risk needs. Our providers are the key to identify the health disparities, and their root causes, that are negatively impacting our members' health.

Coding for SDOH

All network providers should include SDOH codes in their billing so that CenCal Health can better identify members needs and find solutions to help them thrive and achieve optimal health. The categories include:

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z58/Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing
- Z63 – Other problems related to primary support group, including family circumstances
- Z64 – Problems related to certain psychosocial circumstances
- Z65 – Problems related to other psychosocial circumstances

Code	Problems related to education and literacy (8)
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable and unattainable
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.5	Less than a high school diploma
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified

Code	Problems related to employment and unemployment (*11*)
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment

Code	Occupational exposure to risk factors (11)
Z57.0	Occupational exposure to noise
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor

Code	Problems related to housing and economic circumstances (17)
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)

Z59.2	Discord with neighbors, lodgers, and landlord
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified

Code	Problems related to social environment (7)
Z60.0	Problems of adjustment to life transitions (life phase, retirement)
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty (migration, social transplantation)
Z60.4	Social exclusion and rejection (physical appearance, illness, behavior)
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problem related to social environment, unspecified

Code	Problems related to upbringing (19)
Z62.0	Inadequate parental supervision and control
Z62.1	Parental overprotection
Z62.21	Child in welfare custody (non-parental family member, foster care)
Z62.22	Institutional upbringing (orphanage or group home)
Z62.29	Other upbringing away from parents
Z62.3	Hostility towards and scapegoating of child
Z62.6	Inappropriate (excessive) parental pressure
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.812	Personal history of neglect in childhood
Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z62.819	Personal history of unspecified abuse in childhood
Z62.820	Parent-biological child conflict
Z62.821	Parent-adopted child conflict
Z62.822	Parent-foster child conflict
Z62.890	Parent-child estrangement NEC
Z62.891	Sibling rivalry
Z62.898	Other specified problems related to upbringing

Z62.9	Problem related to upbringing, unspecified

Code	Other problems related to primary support group, including family circumstances (*12*)
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.31	Absence of family member due to military deployment
Z63.32	Other absence of family member
Z63.4	Disappearance/death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.71	Stress on family due to return of family from military deployment
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful events affecting family/household (ill/disturbed member)
Z63.8	Other specified problems related to primary support group (discord or estrangement, inadequate support)
Z63.9	Problem related to primary support group, unspecified

Code	Problems related to psychosocial circumstances (3)
Z64.0	Problems related to unwanted pregnancy
Z64.1	Problems related to multiparity
Z64.4	Discord with counselors

Code	Problems related to other psychosocial circumstances (8)
Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.3	Problems related to other legal circumstances (arrest, custody, litigation)
Z65.4	Victim of crime and terrorism
Z65.5	Exposure to disaster, war, and other hostilities
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
Z65.9	Problem related to unspecified psychosocial circumstances

The list is subject to revisions and additions to improve alignment with SDOH data elements.

Reference Links:

Department of Health Care Services All Plan Letter (APL) 21-009
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf

CenCal Health Social Determinants of Health
https://www.cencalhealth.org/providers/social-determinants-of-health/

L10: Basic Population Health Management

Basic Population Health Management (BPHM), is a primary component of CenCal Health's Population Health Management (PHM) Strategy and Program Description as required by the Department of Health Care Service (DHCS) which is a cornerstone of CalAIM. The BPHM is an approach to care that ensures needed programs and services are made available to each member, regardless of the

member's risk and Social Determinants of Health (SDOH), at the right time and in the right setting. CenCal Health maintains a BPHM system and ensures it promotes health equity and provides all members services delivered in a culturally and linguistically competent manner that are responsive to member needs, beliefs, and preferences. All Basic PHM services are aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). .

CenCal Health and the provider network should note the following components of the PHM Strategy and Program Description:

- Gathering member Information: through providers' initial screenings and reporting in claims, encounters, and other data;
- Understanding Risk: where CenCal Health analyzes member medical utilization and personal characteristics through available data to quantify member risk; and,
- Providing Services and Supports: through Basic Population Health Management (BPHM), Care Management, and, as-needed, Transitional Care Services.

Gathering Member Information

Providers are required to report accurate and timely claim and encounter data to CenCal Health. This facilitates CenCal Health's ongoing efforts to gather complete member information and to be able to analyze our members' risks and population needs. Providers should ensure they are also reporting all available (SDOH) diagnosis codes in their claim, encounter, and other report data provided to CenCal Health to ensure proper capture of these factors contributing to the health outcomes of members. More information about SDOH and coding can be found in Section L10: "Social Determinants of Health" of this Provider Manual.

Understanding Risk

CenCal Health aims to help members with their health before they require intensive treatment and care. Therefore, understanding member risk is important as it helps to identify potential interventions that are at the earliest possible point of intervention based on member risk level. CenCal Health utilizes Risk Stratification and Segmentation (RSS) and Risk Tiering to understand members' risk.

Providing Services and Supports

In addition to providing accurate and timely member data, providers have a role in ensuring the delivery of services under this framework and ensuring coordination of services.

BPHM is provided to all members, regardless of their level of need; in contrast to Care Management, which is focused on populations with significant or emerging needs.

The BPHM system includes:

1. Access, Utilization, and Engagement with Primary Care
2. Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports
3. Information Sharing and Referral Support Infrastructure
4. Integration of Community Health Workers (CHWs) in PHM
5. Wellness and Prevention Programs
6. Programs Addressing Chronic Disease
7. Programs to Address Maternal Health Outcomes
8. PHM for Children

Primary Care Providers (PCPs) and Enhanced Care Management (ECM) providers have a unique role in managing care coordination efforts for their assigned members; however, all providers should ensure care coordination and referral support throughout the continuum of care, including coordination with

those lead care management providers in the network (PCPs and ECM providers) to facilitate member access to services.

Providers must ensure coordination of care with all entities, including those agencies that provide services not directly managed by CenCal Health. Those entities include but are not limited to:

- Dental services
- Specialty Mental Health Services
- County Substance Use Services
- California Children's Services (CCS)
- Tri-Counties Regional Center (TCRC)
- Local Education Agency (LEA)
- Medi-Cal's Pharmacy Benefit via Medi-Cal Rx

CenCal Health provides the following resources to providers to assist in this process:

- Systems to electronically track and monitor referrals, including those for care management and the outcomes of those referrals via the Provider Portal.
- A community resource directory available on the CenCal Health website at www.cencalhealth.org.
- A toll-free number to obtain assistance with making referrals. More information on referrals can be found within this Manual on Section H: "Referrals and Authorizations," and Section I "Care Management Programs and Community Support Services."
- Other training and provider supports for working with CenCal Health, as further described in Section B3: "Provider Education and Training Resources" of this Manual.

References:

Policies

- Basic Population Health Management: Identifying & Addressing Member's Needs due to Social Drivers of Health
- Basic Population Health Management: Identifying Members Needing Preventive Services & Increasing Appropriate Preventive Service Utilization

L11: Vaccines for Children (VFC) & Declinations Process

Vaccines for Children (VFC) is a federally funded program that provides free vaccines for eligible children aged 18 or younger (including all Medi-Cal Eligible children age 18 or younger) and distributes immunization updates and relation information to participating providers. CenCal Health encourages all providers who see members aged 18 or younger to enroll as a VFC participating provider to improve access to immunizations.

Providers that are enrolled in the VFC program have access to all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Providers that would like to enroll in the VFC program may do so through eziz.org. CenCal Health providers may also contact the Provider Relations department for support in enrolling in the VFC program.

When providing vaccines to children, appropriate medical documentation protocol must be followed. If any vaccines are refused, documentation must be entered in the member's Medical Record which indicates the services were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of those services.

L12: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

CenCal Health PCPs are required to ensure the provision of all screening, preventive and medically necessary diagnostic and treatment services for members under 21 years of age required under the Early and Periodic Screen, Diagnosis and Treatment (EPSDT) benefit described in Title 42 of the United States Code section 1396d(r) and W&I Code section 14132(v).

The benefits covered under EPSDT are key to ensuring children and youth receive appropriate preventive medical, dental, vision, hearing, mental health, substance use disorder, developmental and specialty services, as well as all medically necessary services to address any defects, illnesses or conditions identified.

The following chart defines the separate components of the EPSDT benefit:

Early	Assessing and identifying problems early
Periodic	Checking member's health at periodic, age-appropriate intervals
Screening	Providing physical, dental, vision, hearing, mental health, developmental and other comprehensive screening exams and tests to detect potential problems
Diagnostic	Performing diagnostic tests to follow up when a risk is identified
Treatment	Control, correct or reduce health problems found

EPSDT services, including preventive health visit anticipatory guidance, must be provided as recommended by the American Academy of Pediatrics (AAP) Bright Futures Guidelines and age-specific assessments and services within the Periodicity Schedule (https://www.aap.org/periodicityschedule) for all members under 21 years of age. The AAP regularly publishes updated tools and resources for use by clinicians and state agencies.

- At each non-emergency primary care visit with a member under 21 years of age, the member (if an emancipated minor), or the parent(s) or guardian of the member, is advised of the children's preventive services due and available from CenCal Health.
- When a request is made for children's preventive services by the member, the member's parent(s) or guardian, or through a referral from the local Child Health and Disability Prevention (CHDP) program, *an appointment must be made for the member to have a visit within ten (10) Working Days of the request*, unless member declines a visit within ten (10) Working Days of the request and another appointment date is chosen by the member.
- Documentation must be entered in the member's medical record indicating receipt of preventive services in accordance with the AAP Bright Futures standards.
- All refusals of children's preventive services must be documented in the member's medical record indicating the services were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of those services.

Medical Necessity

- EPSDT services are medically necessary or a medical necessity if they correct or ameliorate defects and physical or behavioral health conditions discovered through screening as set forth in Title XIX of the Social Security Act, Section 1905(r)(5) and in Welfare and Institutions Code (W&I Code), Section 14059.5(b)(1).
- PCPs must arrange for all medically necessary services identified at a preventive screening or other visit identifying the need for treatment, either directly or through referral to appropriate agencies, organizations, or individuals.
- All medically necessary services must be initiated in a timely manner, as soon as possible, *but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up*.

- If members less than 21 years of age are not eligible or accepted for medically necessary targeted case management services by a Regional Center or local government health program, CenCal Health will arrange for comparable services for the member.
- CenCal Health provides appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for medically necessary services, including all services available through the Medi-Cal program, whether or not they are covered services.

Specialty Mental Health Services

- Covered services do not include Specialty Mental Health Services (SMHS). For these non-covered services, CenCal Health ensures that:
    - The case management for medically necessary services authorized by county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System Plans is equivalent to that provided by CenCal Health for covered services for members under 21 years of age.
    - If indicated or upon the member's request, CenCal Health provides additional Care Coordination and case management services as necessary to meet the member's medical and behavioral health needs.

"Medi-Cal for Kids and Teens"

The Department of Health Care Services (DHCS) refers to EPSDT as "Medi-Cal for Kids and Teens" in outreach and education materials. DHCS has developed child-focused and teen-focused brochures that provide an overview of EPSDT, including Covered Services, how to access those services, and the importance of preventive care. Additionally, DHCS provides guidance that illustrates what to do if Medi-Cal care is denied, delayed, reduced, or stopped, including who to contact, how to file grievances and appeals, and how to access other enrollee assistance resources.

Member Outreach

CenCal Health supports its PCPs by identifying Members who have not utilized EPSDT screening services or AAP Bright Futures preventive services by:

- Making gaps in care reports available via the Provider Portal. Please refer to **Section L4: Quality Care Incentive Program** and **L7: Initial Health Appointment** for details. For additional information, please contact the Population Health team at populationhealth@cencalhealth.org.
- Ensuring outreach to these Members in a culturally and linguistically appropriate manner to increase utilization of clinically recommended services in accordance with established guidelines. For additional information, please contact the Health Promotion team at: healtheducation@cencalhealth.org

Reference Links:

DHCS APL 23-005 Requirements For Coverage Of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the age of 21
APL 23-005 (ca.gov)

American Academy of Pediatrics Bright Futures
https://www.aap.org/en/practice-management/bright-futures/

DHCS Medi-Cal for Kids and Teens Provider Information
https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Provider-Information.aspx

Medi-Cal for Kids & Teens Provider Training
https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/DHCS-EPSDT-Provider-Training-Updated-Feb-2024.pdf

Medicaid.gov: Early and Periodic Screening, Diagnostic, and Treatment
https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

L13: Autism Spectrum Disorder (ASD) Screening

ASD Screenings must be performed at 18 months and 24 months of age based on AAP periodicity "Bright Futures."

If the patient is positive for risk factors, providers should offer and document the follow-up interventions:

- Ages and Stages Questionnaires (ASQ)
- Communication and Symbolic Behavior Scales (CSBS)
- Parents' Evaluation of Developmental Status (PEDS)
- Modified Checklist for Autism in Toddlers (MCHAT)
- Screening Tool for Autism in Toddlers and Young Children (STAT)
- Survey of Well-being of Young Children (SWYC) screening tools (assess three domains of child functioning: developmental domain, emotional/behavioral domain, and family context)

Screening should occur per "identification, Evaluation, and Management of Children With Autism Spectrum Disorder."

Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening", available at: https://pediatrics.aappublications.org/content/145/1/e20193449.

See the AAP publication regarding Identification, Evaluation, and Management of Children with ASD, available at: https://pediatrics.aappublications.org/content/145/1/e20193447.

See the Tufts Children's Hospital Survey of Well-being of Young Children, available at: https://www.tuftschildrenshospital.org/The-Survey-of-Wellbeing-of-YoungChildren/Overview.

See the AAP Screening Tools, available at: https://www.aap.org/en/patientcare/screening-technical-assistance-and-resource-center/screening-toolfinder/?page=1

Referral for BHT Services

Physicians, Psychologists, and Surgeons who recommend Behavioral Health Treatment (BHT) as Medically Necessary should submit an ABA Recommendation Form directly to the Behavioral Health Department at (805) 681-3070 or via secure link at https://gateway.cencalhealth.org/form/bh

An ASD diagnosis is not necessary to start Behavioral Health Treatment, only a recommendation from a physician, psychologist, or surgeon. The member may be eligible if they are medically stable, not in an need of 24 hour nursing or monitoring, and not in an Intermediate Care Facility.

Providers should complete the ABA Recommendation form entirely. Providers mut work with the member to identify an available contracted BHT provider.

Referral for Psychological Testing

Psychological testing utilizes tests and other assessment tools to measure and observe a patient's behavioral to assess diagnosis and guided treatment.

Providers who believe that a member may need psychological testing after completing screening and evaluative methods should refer the member to a contracted psychologist for a psychological evaluation to determine if psychological testing is medically necessary. A referral is not required,

providers may contact any contracted provider to arrange an appointment on behalf of the member or refer the member to the provider for scheduling.

Providers should ensure to provide the psychologist with all relevant evaluative and developmental history and the clinical question that testing would answer.

Billing

Developmental Screening

- CPT Code: 96110 with modifier KX

Developmental Testing

- CPT Code: 96112
- CPT Code: 96113

L14: Depression Screenings

AAP recommends screening for major depressive disorder in adolescents aged 12 to 20 years.

Screenings should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up if screening is positive and a follow up plan is documented.

Depression screening may be completed using a validated screening tool. Commonly used validated screening tools include:

- Patient Health Questionnaire-9 (PHQ-9)
- Patient Health Questionnaire-2 (PHQ-2)

Per AAP, screen using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit, and available at:
https://downloads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf and
https://www.aap.org/en/patient-care/screening-technical-assistance-and-resourcecenter/screening-tool-finder/?page=1

Maternal Depression Screening

Maternal mental health conditions is defined as a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

Providers who provide prenatal or postpartum care for a patient are required to screen or appropriately screen a mother for maternal mental health conditions. Screenings should also occur if the member has experienced a stillbirth or miscarriage (Health and Safety Code, section 123640).

Maternal depression screenings must occur at 1-month, 2-month, 4-month and 6-month visits.

Maternal depression screening must be done using a validated screening tool.

Perinatal Depression Screening

- A Safe Environment for Every Kid (SEEK) Questionnaire-R (PQ-R)
- Edinburgh Postpartum Depression Scale (EPDS)
- Patient Health Questionnaire-9 (PHQ-9)

Per AAP, "screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice', available at: https://pediatrics.aappublications.org/content/143/1/e20183259

See the ACOG Frequently Asked Questions on Postpartum Depression, available at: https://www.acog.org/Patients/FAQs/Postpartum-Depression. See the USPSTF recommendation on Screening Depression in Adults, available at: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1

See the U.S. Department of Health and Human Services guidance on Postpartum Depression, available at: https://www.womenshealth.gov/mental-health/mental-healthconditions/postpartum-depression.

Referrals

Members may be referred, with appropriate consent, for mental health services using the Behavioral Health Care Coordination form to the Behavioral Health Department at (805) 681-3070.

Members do not require a referral or authorization to access mental health services. Members may also contact the Behavioral Health Call Center at (800) 421-2560 to obtain names and numbers of available providers.

Please refer to **E7 Mental Health Services**, **E8 Substance Use Services** and **F2 Specialty Mental Health Services**.

Members may also be referred to Case Management Services, please refer to I3 Care management.

Documentation

Providers should offer and document appropriate follow up interventions(s) for patient whose screening is positive for depression.

Providers should also ensure to document appropriate follow up for referrals.

Billing

- **G8431:** Screening for Depression, Positive Result and Provision of Recommendations Provided.
- **G8510:** Screening for Depression, Negative Result

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.

You may also access the Member Rights & Responsibilities on their own dedicated webpage on CenCal Health's website.

Reference Links:
Member Handbook
https://www.cencalhealth.org/members/member-handbook/

Member Rights & Responsibilities Webpage:
https://www.cencalhealth.org/members/medi-cal/member-rights/

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.

Reference Link:
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

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.

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 (LEP) members. 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 (LEP). We encourage providers to use CenCal Health's 24/7 telephonic/over the phone interpreting (OPI) services for most routine appointments. Video Remote Interpreting (VRI) for ASL, Spanish and 19 other languages are also now available for specialty appointments through Certified Language International (CLI) by using their assigned password. Providers may also request face-to-face interpreter services (Spanish, Mixteco, ASL) if criteria for these services are met for a network interpreter to be sent to the appointment, when available. Providers needing a Mixteco interpreter can pre-schedule these services through Certified Language International (CLI) or directly through CenCal Health if CLI is unable to fulfill the request. 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/ over the phone interpreter service (OPI) 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 spoken languages available on demand. Please note that only ASL and Spanish are 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, Mixteco, 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, please request at least 5 working days in advance notice.
- Mixteco interpreters are available through CLI, but it is recommended that they be requested at least 2 weeks prior to the appointment time. If CLI is unable to fulfill the request the provider may request these services directly from CenCal Health.

- 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
  - For Mixteco members only: Name of the town they are from

- 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.

Reference Link:
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, adhere to interpreter ethical principles, and are 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, video, or face-to-face qualified interpreter services provided by CenCal Health. We recommend documenting that free, qualified medical interpreter services were offered to the member in their preferred language, as well as 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.

Under Section 1557 of the ACA, an accompanying adult can provide interpretation in non-emergency situations if three conditions are met: 1.) a member specifically ask that an accompanying adult be the interpreter, 2.) that accompanying adult agrees to interpret and 3.) "reliance on that adult for such assistance is appropriate under the circumstances. Because providers still maintain the legal responsibility for providing qualified medical interpreters, it is recommended that the provider document for each encounter the details of how all 3 conditions were met.

N4: Tips for Documenting Telephonic, Video or Face-to-Face Interpreter Services

- CenCal Health recommends documenting in the member's medical record:
    - whether the interpreter services were telephonic (OPI), VRI, or face to face
    - interpreter language, including ASL
    - the name of the vendor providing services, i.e., CLI or CenCal Health
    - interpreter name or number
- If the member was offered interpreter services and they refused, it is important to note in the member record for that visit that free, qualified medical interpreter services were offered in the member's preferred language and were refused .
- 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 (LEP) 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.

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.

MICOP, provides trained, qualified, and professional telephonic, and face-to-face Mixteco interpreters who follow established ethical principles when interpreting.

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 & Linguistic Services Manager.

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. . You can also show the member the CLI Language Identification card and have them point to the language that they speak.

- **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. Using a qualified interpreter is always recommended to ensure effective communication and to allow the member to fully understand and express themselves.

- **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 for discussing health care?

N7: Language Access Program

CenCal Health offers language 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.

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
6. For languages of lesser diffusion, like Mixteco, it is suggested that appointments be scheduled 1-2 weeks ahead of time.

- You will need to provide the following information in addition to information listed above:
    a. Date, time, and time zone for the scheduled call
    b. Estimated call duration
    c. Language needed (for Mixteco must share name of the town the member is from)
    d. Contact name and phone number
    e. Nature of call
    f. Request to be informed at least 3 days prior to the appointment id they are unable to cover the appointment
- You will be given:
    - A reference number for the appointment
    - a confirmation once an interpreter is secured

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 Linguistic Services Manager will schedule a qualified interpreter for the requested date of service. For more information regarding Language Assistance, please visit CenCal Health's website.

Reference Links:

User Guider for VRI
cencalhealth.org/wp-content/uploads/2021/10/clivriuserguidewithbluestreatmtechsupport202003.pdf

VRI Frequently Asked Questing
clivrifaq202003.pdf (cencalhealth.org)

VRI Minimum Requirements
cencalhealth.org/wp-content/uploads/2021/10/clivriminimumrequirements202003-1.pdf

N8: Language Assistance

ATTENTION: If you speak a language other than English, qualified language assistance services are available to you free of charge. 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).

Reference Link:
CenCal Health Language Assistance Taglines
https://www.cencalhealth.org/wp-content/uploads/2023/07/Tagline-CenCal-Health-M-MS-HIYL-0623-new.pdf

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's operations and direction, as appropriate.

Accordance with California Code of Regulations (28 CCR 1300.68) and the DHCS guideline (APL 21-011, *Grievance and Appeal Requirements, Notice and "Your Rights" Templates).*

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 Representative (PSR) 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 (5) 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 will 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 report shall summarize the number and type of provider complaints, ses, and appeals.

O2: Member Grievance and Appeal Process

CenCal Health members have a right to file grievances and to request appeals, as well as a right to obtain a copy of their medical record. Providers or authorized representatives can offer to help members file a grievance or an appeal. They can also file appeals on their behalf with the member's written consent. 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. Members have a right to request continuation of benefits while an appeal is in progress. An appeal or grievance can be made by the member, the authorized representative or by a provider on behalf of the member, with their written consent.

Discrimination Grievances – These types of grievances are processed by a Discrimination Grievance Coordinator to ensure the health plan is in compliance with federal and State nondiscrimination requirements and investigating cases related to any action that would be prohibit by, or out of compliance with, federal and State requirements.

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/

CenCal Health also offers members assistance in filing grievance, appeals, or State Fair Hearings, including providing members any necessary forms and providing auxiliary aids and services, when requested (such as interpreter services or documents in alternative formats).

Standard and Expedited Review Processes

Standard - In most circumstances, grievance or appeal requests will be processed through the Standard Grievance/Appeal Review Process, which allows a 30-day maximum 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 includes a written resolution of the grievance or appeal within 30 calendar days of filing.

Expedited - An expedited review of a grievance or appeal can be requested in certain cases, which allows a 72-hour timeframe from the day it is received and consented to by member. 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 verbally to the requestor within 72 hours of filing. Written notification is also provided within 72-hours in most cases, however, can be delayed for translation needs.

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. Attempts will be made to verbally notify the member or authorized representative of this change to a standard 30-day process, and the verbal notification is also followed by a written Acknowledgement Letter initiating the standard grievance or appeal.

Medi-Cal State Fair Hearing Process for Members

Upon CenCal Health's denial of a member's appeal for a treatment or service, Members have a right to request a State Fair Hearing. Members may request the State Fair Hearing from the Department of Social Services (DSS) within 120 days of the date of the Notice of Appeal Resolution Letter (NAR) they received from CenCal Health denying the member's appeal for a treatment or service.

Medi-Cal members can ask for a State Fair Hearing by phone or in writing at:
California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 09-17-37
Sacramento, CA 94244-2430

Phone: 1(800) 952-5253 (Voice) or 1(800) 952-8349 (TDD/TTY)

State Fair Hearing Request Forms are attached to NAR Letters. Members have a right to request continuation of benefits while a State Fair Hearing is in progress. Members may have representation at hearings. If the member needs an interpreter, an interpreter will be provided at no cost.

If the case is presented at a hearing before a DSS administrative law judge, the DSS judge generally makes a final decision within 90 days from the date of filing a request for hearing or within three (3) business days if an expedited hearing was granted.

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 calendar days at a maximum) from the date of the notification.

If providers would like to file a grievance or appeal on behalf of a member, providers must obtain written consent from members to do so. This signed consent should be submitted with your appeal request. CenCal Health is able to initiate a grievance or 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 grievance or appeal request. Copies of these forms are available on the following links:
Appeal Form: English or Spanish (location on website - https://www.cencalhealth.org/members/file-complaint/)
- Member Appeal Form – English
- Member Appeal Form – Spanish

Grievance Form: English or Spanish also located at https://www.cencalhealth.org/members/file-complaint/
- Member Grievance Form – English
- Member Grievance Form – Spanish

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 materials and interventions for your patients.

CenCal Health can provide education, training, and program resources to assist in the delivery of health education services for your patients.

For information to support health education services in your practice, contact the Health Promotion team at healthed@cencalhealth.org or (800) 421-2560 ext. 3126.

Resources for CenCal Health Members

CenCal Health members can be referred to the Health Education Request Line at (800) 421-2560 ext. 3126 or to their Member Portal account to request specific materials or other health education needs from CenCal Health.

CenCal Health's online library of patient education materials (linked below) are available to members at no cost, in English and Spanish, on the Health and Wellness section of our website.

CenCal Health members can also access evidence-based self-management tools on our website (linked below) for the management of conditions or behaviors. These self-management tools are interactive resources that allow members to determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk.

Reference Link:
CenCal Health and Wellness
https://www.cencalhealth.org/health-and-wellness/

CenCal Health Self-Management Tools
https://www.cencalhealth.org/health-and-wellness/self-management-tools

Section Q: Fraud Waste and Abuse (FWA) & Protected Health Information (PHI)

Q1: Overview of Fraud, Waste and Abuse

CenCal Health is dedicated to the detection, investigation, prevention, and reporting of suspected or actual fraud, waste, and abuse (FWA). CenCal Health's Fraud Program is designed to prevent and detect suspected and or actual FWA. The Special Investigations Unit (SIU) in the Compliance Department investigates all reports of suspected FWA. The SIU works in tandem with state and federal agencies, as well as law enforcement, to report individuals or organizations who may be involved in FWA activities.

CenCal Health maintains and supports reporting of any suspected FWA through variety of reporting channels including an anonymous reporting hotline. 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.

For more information on FWA, please visit our CenCal Health website page on Fraud at http://www.cencalhealth.org/providers/suspect-fraud.

Under the terms of the contract between CenCal Health and its provider network, providers must report suspected cases of FWA to CenCal Health. This section of the Provider Manual provides general guidance for providers and subcontractors in identifying and reporting FWA to CenCal Health.

Q2: Fraud Waste and Abuse (FWA) Definitions

- Fraud means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person, and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I Code section 14043.1(i).
- Waste means the overutilization or inappropriate utilization of services and misuse of resources.
- Abuse means practices that are inconsistent with sound fiscal and business or medical practices, and result in unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

Q3: Health Care Examples of Fraud

For FY 2022[2], The Department of Health and Human Services, Office of Inspector General reported a little over $1.3 billion dollars in expected recoveries. Health care fraud harms both patients and taxpayers. Below are examples of Member and Provider FWA that must be reported to CenCal Health

- Member/Beneficiary:
  - Failure to report other health coverage;
  - Loaning, giving, or using another individual's identity, Beneficiary Insurance Card (BIC), CenCal Health identification card, Medi-Cal number, or other documentation of Medi-Cal or CenCal Health eligibility to obtain covered services, unless such person is an authorized representative who is presenting such document or information on behalf of a Member to obtain covered services for that Member;
  - Selling a Member's identity, BIC, CenCal Health identification card, Medi-Cal number, or other documentation of Medi-Cal or CenCal Health's eligibility;
  - Using a Covered Service for purposes other than the purposes for which it was prescribed or provided, including use of such Covered Service by an individual other than the Member for whom the covered service was prescribed or provided;
  - Soliciting or receiving a kickback, bribe, rebate, or other illicit incentive, as outlined in the Federal Anti-Kickback Statute, as an inducement to receive or not receive Covered Services; and,
  - Impersonating a provider or falsifying provider documentation to obtain unauthorized items (e.g. prescription medications, durable medical equipment).
- Provider:
  - When an individual or provider recruits and pays individuals money or offers gifts in exchange for referrals in the Medicare or Medi-Cal program;
  - Billing for services not rendered or at a higher level than actually provided;
  - Billing for non-covered services using an incorrect CPT3, HCPCS4 and/or Diagnosis code in order to have services covered;
  - Billing for services that are performed by another provider or services performed by an unlicensed provider, yet billed under a licensed provider's name or information;
  - Altering records to receive covered services;
  - Ordering unnecessary tests or diagnostic procedures.

Q4: Reporting Fraud, Waste or Abuse (FWA)

CenCal Health's contract between a Provider or Subcontractor includes terms requiring contracted entities to report suspected cases of Fraud, Waste and Abuse (FWA) within ten (10) business days of the date the Provider first becomes aware of or is on notice of such activity. Federal law also requires repayment of the overpayment to CenCal Health within sixty (60) calendar days after the date on which the overpayment was identified. 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 (if available and applicable):

- **Actor (s) or Suspect (s) Identification and Contact Information:** Name, Address and License or Insurance ID.
- **Incident Description and Details:** who, what, where, when, date and time of incident(s).
- **Incident Documentation:** Any documentation you may have related to the incident(s).
- **Reporter Contact Information:** Your name, telephone number (if you would like to be contacted).

[2] Source: Semiannual Report to Congress (hhs.gov) October 1, 2022 – March 31, 2023
[3] Current Procedural Terminology (CPT®)
[4] Healthcare Common Procedure Coding System

Any person may report a suspected FWA matter to CenCal Health through the following mechanisms:

CenCal Health
FWA Reporting Contacts

Reporting Channel	Contact Information	Contact Details
☎ FWA Hotline (Phone)	(866) 775-3944	This hotline is operated by a third-party vendor of CenCal Health which: • Operates 24-hours a day, 7-days a week; • Maintains reporter confidentiality; • Offers anonymous reporting; and • Provides English and Spanish language.
Online	https://cencalhealth.alertline.com/gcs/overview	This is an online reporting system, hosted by a CenCal Health vendor. **To file a report:** 1. Click the link or enter the URL into your browser. 2. Select the "Make a Report" link at the top of the web page. 3. After you complete your report, you will be assigned a unique code called a "report key." 4. Write down your report key and password and keep them in a safe place. 5. After 5-6 business days, use your report key and password to check your report for feedback or questions.
Email	compliance@cencalhealth.org	Please send via secured email for reports containing PHI.
Mail	CenCal Health Fraud Investigations Compliance Department 4050 Calle Real Santa Barbara, CA 93110	
Fax	(805) 681-8279	Please send “ATTN: Compliance Department”
☎ Chief Compliance Officer & Fraud Prevention Officer (Phone)	(877) 814-1861	This is CenCal Health’s toll-free number. When speaking to a Member Services Representative, you may ask to speak to the Chief Compliance Officer as you would like to report Fraud, Waste or Abuse.

Government Agencies & CenCal Health Regulators
FWA Reporting Contacts

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
Health and Human Services (HHS) Office of Inspector General (OIG)	
☎ Phone	(800) HHS-TIPS (800-447-8477)
Online	https://oig.hhs.gov/fraud/report-fraud

Q5: Investigation of Fraud, Waste, or Abuse (FWA)

CenCal Health identifies, investigates, and responds to all allegations of suspected FWA from Members, providers, regulators, and internal CenCal employees. Investigations into suspected FWA are performed by the Special Investigation Unit (SIU) in the Compliance Department and overseen by CenCal Health's Chief Compliance and Fraud Prevention Officer.

During the investigation process, CenCal Health will review for FWA, which may include verifying whether services that have been represented to have been delivered by a Provider were received by members. During such verification, the provider may be asked to allow CenCal access to the medical record and billing documents that support the charges billed on either a prepayment or post-payment review basis. The provider may also be required to comply with any onsite audits or interviews requested by CenCal Health. In the event the provider does not submit or refuses to provide medical records or otherwise comply with the investigation, the provider may receive a denial or a request for recovery of payment.

In the event that CenCal Health determines that FWA occurred, the provider will be notified of the findings by a letter providing an explanation of any overpayment. The provider may be required to repay the amount through a one-time payment, payment plan, or offsets to future claims payments , as determined by CenCal Health. As directed or permitted by state law, regulation, or contract, CenCal Health may determine the overpayment amount through extrapolation of investigation findings for a particular provider obtained through a Statistically Valid Random Sample audit.

Investigations and cases shall be approved for closure upon final review of the case documentation, data, and findings by the Chief Compliance and Fraud Prevention Officer and/or designee. The Provider may have the right to dispute the results of the investigation.

The Compliance Investigator in collaboration with the Chief Compliance and Fraud Prevention Officer and/or designee shall determine the appropriate remediation steps to prevent or deter future FWA. Potential remediation steps may include, but are not limited to: (i) termination of the provider contract, (ii) revocation of delegation of activities, (iii) additional prepayment or post-payment review of claims, (iv) additional monitoring, reporting, or educational requirements, or (v) referral to DHCS' Program Integrity Unit or law enforcement.

Q6: 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 policies and procedures are in place;
4) ensure members are able to timely access their own PHI;
5) reminder of confidentiality and privacy provisions under Network Provider Agreements; and
6) how to identify and report privacy incidents and breaches to CenCal Health.

Safeguarding PHI

As HIPAA covered entities, CenCal Health and its network 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.

Policies and Procedures

Providers must have policies and procedures in place to guard against unlawful disclosure of PHI, Personal Information (PI), and any other confidential information to any unauthorized persons or entities. Examples of policies and procedures include but are not limited to:

- Uses and Disclosures of PHI
- Minimum Necessary Disclosures of PHI
- Authorization for Release of PHI

Member Access to PHI

The HIPAA Privacy Rule requires CenCal Health and its network 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.

Confidentiality and Privacy Provisions Under Network Provider Agreements

Providers are required to comply with all provisions of Confidentiality of Information in their Network Provider Agreements.

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, within 24 hours from discovery report both privacy incidents and breaches involving CenCal Health members to CenCal Health.

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


Online: https://cencalhealth.alertline.com/gcs/overview


E-mail: HIPAATeam@cencalhealth.org


Fax: (805) 681-8279


Mail: CenCal Health
Attn: Privacy Office
4050 Calle Real, Santa Barbara, CA 93110

Section R: 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