Authorization for Medical Services and DME

Basics
Certain procedures/services require prior authorization from CenCal Health before the service is rendered and reimbursement can be made. An authorization is needed to ensure that requested benefits are medically necessary, do not exceed health services received by the general public for similar services, and are the lowest cost item or service covered by the program which meets the member's medical needs. For the all programs administered by CenCal Health, we generally follow Medi-Cal guidelines, but providers are urged to check our website for additional codes for which we require authorization. Questions concerning authorization for medical services or for Durable Medical Equipment (DME) should be directed to the central UM line at 805.562.1082.

Forms
Providers should use a Treatment Authorization Request form (TAR) for Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) members. These forms are supplied by EDS and can be obtained by calling (800) 541-5555. For members of the Healthy Families (HF), Healthy Kids (HK), Prenatal PLUS 2 (PP2), and In-Home Supportive Services (IHSS) programs, providers should use an Authorization Request (AR). Information regarding obtaining AR forms can be found in "Ordering Authorization Requests" in this section of the Provider Manual.

Eligibility
A member's eligibility should always be confirmed prior to submitting a TAR/AR. Providers should ensure the member is eligible with a CenCal Health program and verify if the member has other health care coverage. A referral does not guarantee a member's eligibility.

Is a Referral Authorization Form (RAF) required when submitting an authorization request?
If the member is case managed, a RAF from the member's current PCP must be on file when the TAR/AR is submitted. DME and Pharmacy providers may submit a prescription from the PCP in place of the RAF if it is specific to the recommendations of the TAR/AR. The RAF number should be entered on the TAR/AR and a copy attached before submittal. If a provider uses the Electronic Treatment Authorization Form (*e*TAR) accessible via our website, they do not need to submit another copy of the RAF, but should instead enter the RAF number where indicated. If you have any problems obtaining a RAF, please contact the Provider Services department at 805.562.1676.

Medical Necessity / Diagnosis
The member's diagnosis using an ICD9-CM diagnosis code must be written in the "Diagnosis/Description" box on the TAR/AR. A statement of the member's medical condition should be written in the box labeled "Diagnosis and Medical Justification", and/or a copy of recent chart notes, consultation letter(s), or the discharge summary should be attached. This requisite information will facilitate a timely review of your request.

Requests for Inpatient/Outpatient Services
1. Physicians requesting an authorization for an inpatient admission are required to enter the provider number of the admitting hospital in Box 3.
2. Physicians requesting an authorization for a procedure that is to be done on an outpatient basis are required to enter the physician's provider number in Box 3.
3. The name of the hospital where the service is being performed or where the member is being admitted must be entered in the "Medical Justification" section.
4. The member's full name and address should be entered, including zip code, phone number, if available, and the member's identification number.
5. Attach a copy of the RAF (or enter the RAF number) if applicable.

Length of Stay
When requesting authorization for elective admissions to acute care hospitals, physicians need to be aware that days assigned on the TAR/AR represent approval for the admission and the days specified. It confirms that the information provided for medical necessity has been met. Days initially approved are NOT to be construed as total length of stay. Additional time may be approved by CenCal Health's Utilization Management Department.

Authorization Requests for Medi-Cal / Medicare (Medi-Medi) Members
Medi-Cal is always the payor of last resort. Authorizations for services that are a Medicare benefit should first be submitted to Medicare for approval. Services that are not a Medicare benefit may be submitted directly to CenCal Health. Providers should refer to their EDS Provider Manual for the services that Medicare does not cover. When referring to the manual, please note that members who have coverage through a Medicare HMO may have additional coverage that is not offered through the traditional Medicare program. Furthermore the member may have Medicare Part B (outpatient) but not Part A (inpatient) coverage. If the member does not have Part A, then Medi-Cal is the payor for their hospitalization and an authorization is required for elective admissions.

If a member has Part A Medicare, an authorization is not required for Part A Medicare covered services.

Authorization Requests for Members with Other Health Care Coverage (OHC)

If a member has dual coverage, the private health insurance always acts as the primary insurance carrier. Authorizations and claims should first be submitted to the other insurance carrier. Once providers have received an EOB or a denial, they may then submit a TAR/AR for those services that require authorization.

Authorization Requests for DME

Prior authorization is required for DME when:

- The cost of the purchase exceeds $100.00
- The cumulative rental costs exceed $50.00
- When the cost of repair or maintenance of wheelchairs exceeds $250.00
- When Oxygen (code E0441) totals more than 10 units in one calendar month
- Unlisted or "by report" items exceeding $50.00

All requests, except those for DME repairs, require proof of medical necessity, and a RAF or prescription. Proof of certification or medical necessity must contain the following:

- Prescription date
- Provider's name, address, and phone number
- Provider's signature
- Items prescribed
- Medical condition necessitating the item
- Duration of medical necessity

All requests must include the following information:

- Diagnosis
- Quantity
- Description of item(s)
- Medical justification
- Rental or purchase modifier
- HCPCS codes
- Rental period (if applicable)
- Provider's signature
- For unlisted items, the description, copies of catalog pages, and the vendor's invoice or the Manufacturer's Suggested Retail Price (MSRP) list

Submittal Requirements

All information requested on the TAR/AR pertaining to the provider and member must be entered, including:

- Member's name, ID number, gender, age, and date of birth
- Provider's name, address, ID, phone number and fax number
- Diagnosis to justify the service requested.

Checklist:

√ Is the patient eligible with a CenCal Health program?
√ Does the patient have other health coverage?
√ If so, is it Medicare - Part A or Part B?
√ Are all patient information areas completed?
√ Is a RAF required and if so, is a copy attached?
√ Is there sufficient documentation to support medical necessity for this service?

Submission Methods

1. Submit online by using the *e*TAR located on our website under Providers Only>>Authorizations.
2. Mail the original TAR/AR with the necessary accompanying documentation to CenCal Health, Attention UM Dept., 4050 Calle Real, Santa Barbara, CA, 93110. Providers should include a copy of the RAF if the member is case managed by a PCP.
3. Fax a copy of the TAR/AR with necessary accompanying documentation to 805.692.5140. Providers do not need to mail the TAR/AR once faxed. Providers should include in the fax a copy of the RAF if the member is case managed by a PCP.

***e*TAR – Getting Started**

1. Providers need a username and password for the protected section of our website.
2. Both PCPs and Referral Providers must have provided an email address specific for the *e*TAR.
3. For assistance in creating an email address or username and password, providers can contact the Webmaster by calling 805.562.1676 or by sending an email to webmaster@cencalhealth.org.

If Your Authorization Request is Returned

What do Approved, Approved as Modified, Deferred, Denied or Returned for Administrative Reasons mean?

Each TAR/AR processed by CenCal Health includes a review by a qualified Health Services Department staff member. The provider's copy is returned or e-mailed with the outcome of the request clearly indicated.

APPROVED: The requested service is approved during the specified time period.

DEFERRED: Read the reviewer's comments on the returned TAR/AR carefully. Submit the additional information requested immediately or the TAR/AR will be subject to denial.

DENIED: The services requested have been denied. The returned TAR/AR states specifically why this decision was made. A description of the appeal process is attached to the denied request.

APPROVED AS MODIFIED: The TAR/AR is returned approved contingent on certain modifications. Modifications could include a denial or reduction in the original quantity requested. The reasons for a denial or reduction will be clearly indicated on the returned TAR/AR.

ADMINISTRATIVE REVIEW RETURN: The TAR/AR has been returned due to missing information and/or another administrative reason. Read the reviewer's comments and resubmit the request immediately.