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New Provider Training

Primary Care Provider

Training Orientation Agenda

- Medi-Cal Coverage & CenCal Health Mission
- CenCal Health New Member Integration
- Member Eligibility & Benefits
- Quality Care Incentive Program
- Provider Resources
- Authorizations
- Radiology Benefit
- Claims & Billing

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Overview of CenCal Health

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Who is CenCal Health?

1983
Founded in 1983 as Santa Barbara Regional Health Authority

1st
First managed care Medi-Cal plan of its type (COHS)

2008
Began serving San Luis Obispo County in 2008

239,237
CenCal Health Membership
As of July 2024

TWO
Exclusive full-scope Medi-Cal plan in our two counties

Responsible for all covered benefits except carve-outs: Prescription drugs, dental care, SED behavioral care

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Our 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

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

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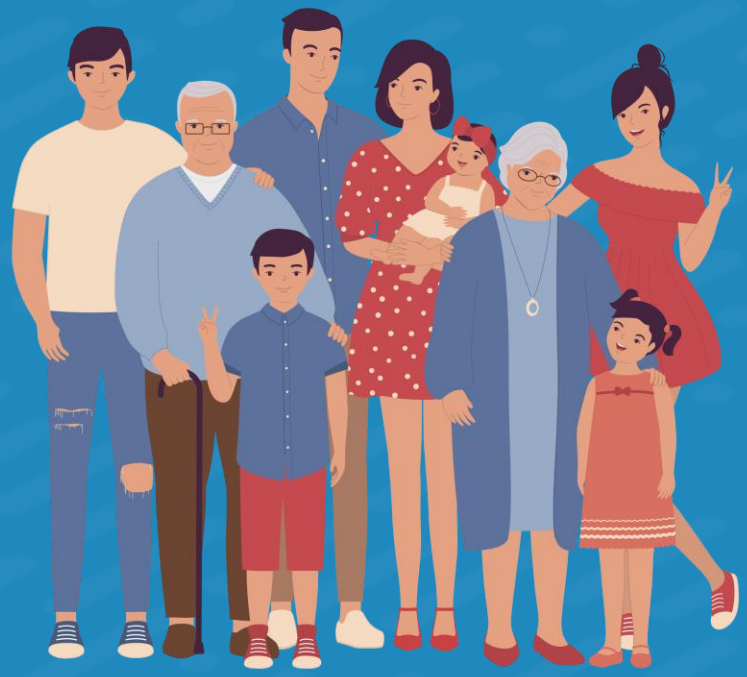
CenCal Health Programs

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.

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



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https://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx

Member Eligibility & Benefits

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What is Covered California and Medi-Cal?

Covered California is the state's health insurance marketplace where Californians can shop for health plans and access financial assistance.

www.coveredca.com/apply/

Medi-Cal offers low-cost or free health coverage to eligible Californian residents with limited income.

Health plans available through Medi-Cal and Covered California both offer a similar set of important benefits, called essential health benefits.

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New Medi-Cal Eligible Person

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Ways to check CenCal Health Member Eligibility

- **Online** verification on CenCal Health Provider Portal

- **Call** the Member Services Department (877) 814-1861
- Primary Care Providers, can reference their assigned members on the CenCal Health Provider Portal via the Coordination of Care module

Additional Resources: cencalhealth.org/providers/eligibility

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New CenCal Health Members

New Members receive:

- Welcome Packet
- CenCal Health ID card
- Member Handbook & Benefits
- A welcome call from our Health Navigators

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https://www.cencalhealth.org/members/member-handbook/

Member Services

Our Member Services Department is a great resource to answer questions, members have about their coverage.

Help with:

- Finding a doctor & scheduling appts.
- Benefit Questions
- Billing Issues
- DME (Durable Medical Equipment
- Filing Complaints/Dissatisfactions & Appeals
- Transportation
- Interpreter Services
- Referrals to CenCal Health's Case Management Team
- Obtaining Referrals and Treatment Authorization Requests
- Continuity of Care
- Provide Eligibility to Providers
- Appointment of Representative Forms

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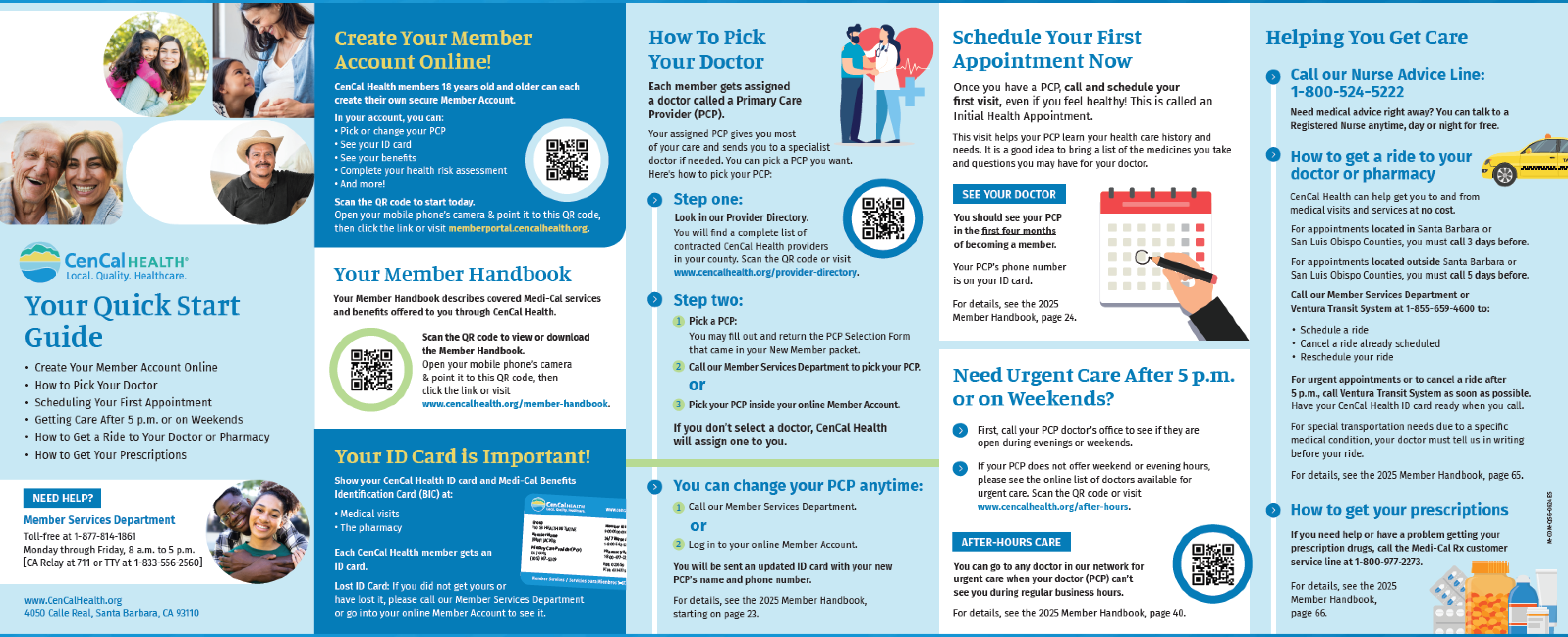
Hours:

Monday - Friday,
8 a.m. - 5 p.m.

Call:

Toll-free at 1-877-814-1861
(TTY/TDD 1-833-556-2560 or 711)



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Your Quick Start Guide

- Create Your Member Account Online
- How to Pick Your Doctor
- Scheduling Your First Appointment
- Getting Care After 5 p.m. or on Weekends
- How to Get a Ride to Your Doctor or Pharmacy
- How to Get Your Prescriptions

NEED HELP?

Member Services Department

Toll-free at 1-877-814-1861
Monday through Friday, 8 a.m. to 5 p.m.
[CA Relay at 711 or TTY at 1-833-556-2560]

www.CenCalHealth.org
4050 Calle Real, Santa Barbara, CA 93110

Create Your Member Account Online!

CenCal Health members 18 years old and older can each create their own secure Member Account.

In your account, you can:

- Pick or change your PCP
- See your ID card
- See your benefits
- Complete your health risk assessment
- And more!

Scan the QR code to start today.
Open your mobile phone's camera & point it to this QR code, then click the link or visit memberportal.cencalhealth.org.

Your Member Handbook

Your Member Handbook describes covered Medi-Cal services and benefits offered to you through CenCal Health.

Scan the QR code to view or download the Member Handbook.
Open your mobile phone's camera & point it to this QR code, then click the link or visit www.cencalhealth.org/member-handbook.

Your ID Card is Important!

Show your CenCal Health ID card and Medi-Cal Benefits Identification Card (BIC) at:

- Medical visits
- The pharmacy

Each CenCal Health member gets an ID card.

Lost ID Card: If you did not get yours or have lost it, please call our Member Services Department or go into your online Member Account to see it.

How To Pick Your Doctor

Each member gets assigned a doctor called a Primary Care Provider (PCP).

Your assigned PCP gives you most of your care and sends you to a specialist doctor if needed. You can pick a PCP you want. Here's how to pick your PCP:

Step one:

Look in our Provider Directory.
You will find a complete list of contracted CenCal Health providers in your county. Scan the QR code or visit www.cencalhealth.org/provider-directory.

Step two:

1. **Pick a PCP:** You may fill out and return the PCP Selection Form that came in your New Member packet.
2. **Call our Member Services Department to pick your PCP.**

or

3. **Pick your PCP inside your online Member Account.**

If you don't select a doctor, CenCal Health will assign one to you.

You can change your PCP anytime:

1. Call our Member Services Department.

or

2. Log in to your online Member Account.

You will be sent an updated ID card with your new PCP's name and phone number.

For details, see the 2025 Member Handbook, starting on page 23.

Schedule Your First Appointment Now

Once you have a PCP, **call and schedule your first visit**, even if you feel healthy! This is called an Initial Health Appointment.

This visit helps your PCP learn your health care history and needs. It is a good idea to bring a list of the medicines you take and questions you may have for your doctor.

SEE YOUR DOCTOR

You should see your PCP in the first four months of becoming a member.

Your PCP's phone number is on your ID card.

For details, see the 2025 Member Handbook, page 24.

Need Urgent Care After 5 p.m. or on Weekends?

- First, call your PCP doctor's office to see if they are open during evenings or weekends.
- If your PCP does not offer weekend or evening hours, please see the online list of doctors available for urgent care. Scan the QR code or visit www.cencalhealth.org/after-hours.

AFTER-HOURS CARE

You can go to any doctor in our network for urgent care when your doctor (PCP) can't see you during regular business hours.

For details, see the 2025 Member Handbook, page 40.

Helping You Get Care

Call our Nurse Advice Line: 1-800-524-5222

Need medical advice right away? You can talk to a Registered Nurse anytime, day or night for free.

How to get a ride to your doctor or pharmacy

CenCal Health can help get you to and from medical visits and services at no cost.

For appointments located in Santa Barbara or San Luis Obispo Counties, you must **call 3 days before.**

For appointments **located outside** Santa Barbara or San Luis Obispo Counties, you must **call 5 days before.**

Call our Member Services Department or Ventura Transit System at 1-855-659-4600 to:

- Schedule a ride
- Cancel a ride already scheduled
- Reschedule your ride

For urgent appointments or to cancel a ride after 5 p.m., call Ventura Transit System as soon as possible. Have your CenCal Health ID card ready when you call.

For special transportation needs due to a specific medical condition, your doctor must tell us in writing before your ride.

For details, see the 2025 Member Handbook, page 65.

How to get your prescriptions

If you need help or have a problem getting your prescription drugs, call the Medi-Cal Rx customer service line at 1-800-977-2273.

For details, see the 2025 Member Handbook, page 66.

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Brochure available in English and Spanish and a supply order can be made available by emailing your Provider Relations Representative at psrgroup@cencalhealth.org

Member Rights and Responsibilities

- CenCal Health is required to inform its members of their rights and responsibilities and ensure that members rights are respected and observed. CenCal Health provides this information to members in the Member Handbook upon enrollment, annually in the member newsletters, on CenCal Health website and upon request
- Providers are required to post the members' right and responsibilities in the waiting room of the facility which services are rendered
- Members have the right to:
  - Be treated with respect and dignity by all CenCal Health and provider staff
  - Privacy and to have medical information kept confidential
  - Get information about CenCal Health, our providers, provider services and their member rights and responsibilities
  - Choose a doctor within CenCal Health's network
  - Talk openly with health care providers about medically necessary treatment options, regardless of cost benefits
  - Get information about their medical condition and treatment plan options in a way that is easy to understand

Member Rights and Responsibilities (cont.)

- Members have the right to:
  - Help make decisions about their health care, including the right to say “no” to medical treatment
  - Voice complaints or appeals, either verbally or in writing, about CenCal Health or the care we provide
  - Get oral interpretation services in language that they understand
  - Make an advance directive
  - Access family planning services, federally qualified health centers, Indian Health Services facilities, sexually transmitted disease services and emergency services outside of CenCal Health’s network
  - Ask for a stated hearing, including information on the conditions under which a state hearing can be expedited
  - Have access to their medical record and where legally appropriate, get copies of, update or correct their medical record
  - Access minor consent services
  - Get written member information in large-size print and other formats upon request and in a timely manner for the format being requested
  - Be free from any form of control or limitation used as a means of pressure, punishment, convenience or revenge

Member Benefits Include:

- Primary care
- Specialty care
- Durable Medical Equipment
- Self-referral services
- Pharmacy
- Emergency care & After Hours Care
- Inpatient and outpatient hospital care
- Diagnostic services (lab, x-ray, imaging)
- Mental Health & Behavioral Health Services
- Enhanced Care Management & Community Support Services

Services Covered by Other Agencies:

- Dental Services (Denti-Cal)
- Specialty Mental Health Services
- County Substance Use Services
- Tri County Regional Center
- Local Education Agency
- Medi-Cal Rx Pharmacy Benefit

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Additional resources listed in Section B of the Provider Manual

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 PCP 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 PCP.

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

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Preventive Services & Early, Periodic Screening, Diagnosis and Testing (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**
- Medically necessary services to address any defects, illnesses or conditions identified.

Click here to download the Medi-Cal for Kids & Teens Provider Training, scan this QR code or go to cencalhealth.org/providers/provider-training-resources/

American Academy of Pediatrics Preventive Care/Periodicity Schedule
www.aap.org/periodicityschedule

Responsibilities of the Primary Care Provider (PCP)

Members are considered 'Special Class' so they can pick a PCP that best fits their needs (closest to home, language available, CCS paneled, etc.)

The PCP is responsible for the management of patient's care. The PCP office issues Referral Authorizations Form (RAF) for specialty care

Provide care for the majority of healthcare issues presented by the member, including preventive, acute, and chronic healthcare

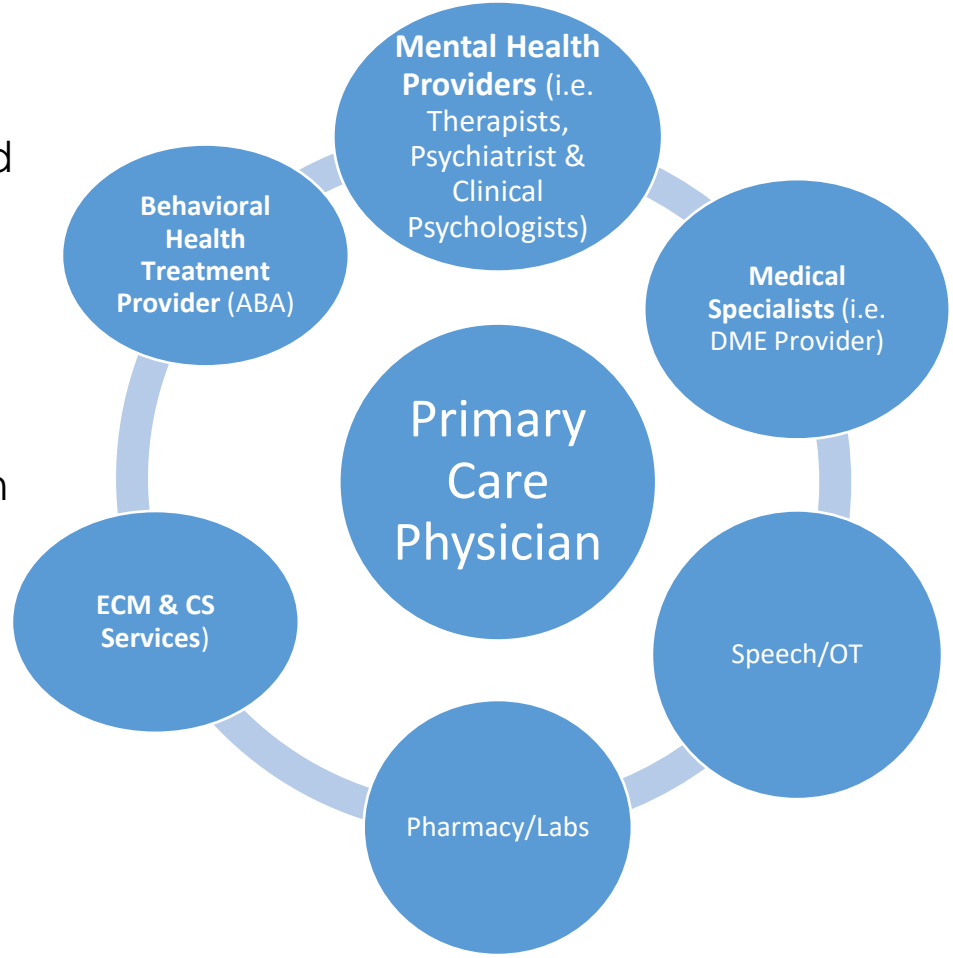
Supply risk assessment, treatment planning, coordination of medically necessary services, referrals, follow up and monitoring of appropriate services, and resources required to meet the needs of the member.

Member Assistance
1 (877) 814-1861

Responsibilities of the Primary Care Provider (PCP)

Coordinate and direct appropriate care for members, including:

- Initial Health Assessments
- 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.



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Member Access & Appointment Waiting Time Standards

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

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After Hours Care

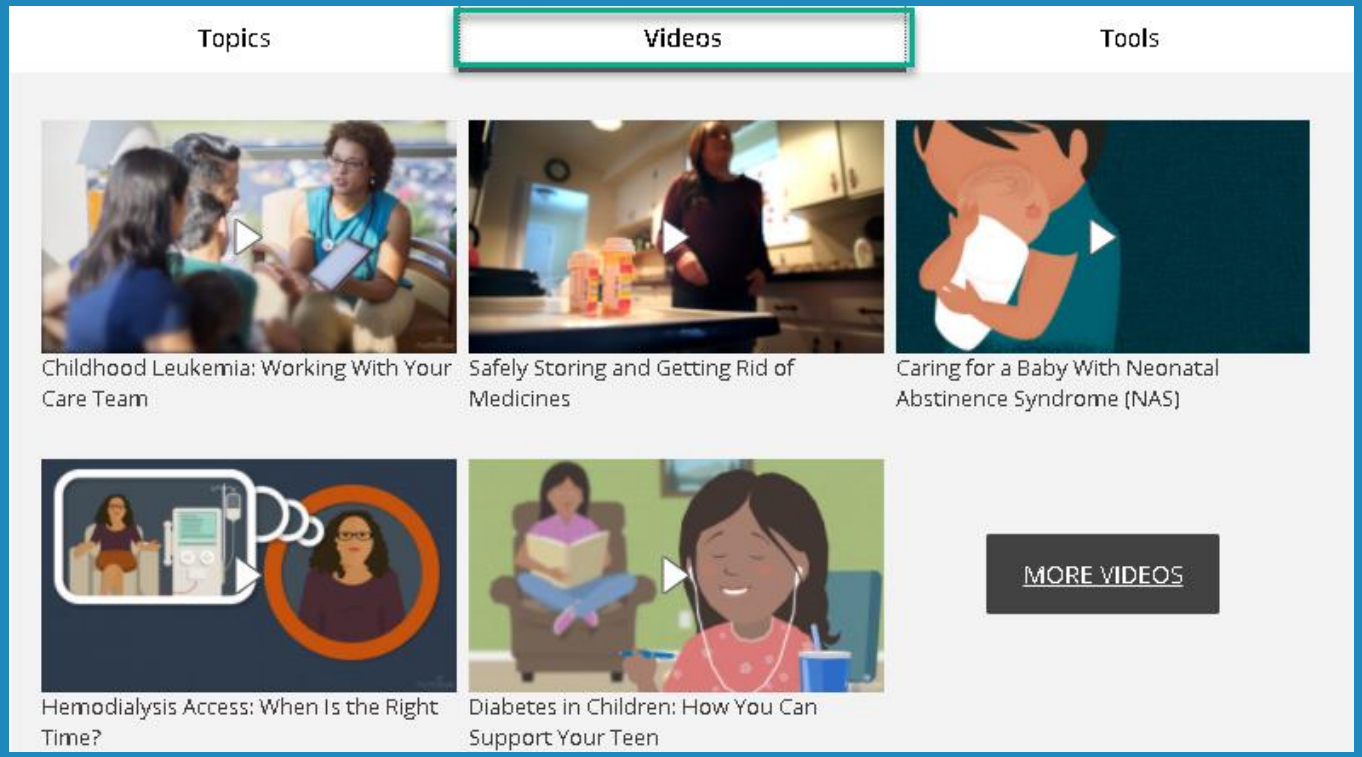
Members can see a doctor after 5 pm or on weekends for urgent care!

Sometimes, members feel sick or get hurt after their doctor's office has closed. If they feel like they need care and can't wait until their doctor's office is open, here's how members can get care weekdays after 5pm and on weekends:

- Call their assigned PCP doctor's office to see if it offers evening or weekend hours. If so, call to make an appointment or simply walk in.

- If the member's assigned PCP does not offer weekend or evening hours, a member can call one of the PCPs listed on our After Care handout, even if they are not their assigned patient.
  - Members just need to tell them they are calling for urgent care needs and need an after-hours or weekend appointment.
  - Members do not need a referral (permission) from your PCP doctor for After Hours Urgent Care services.

Nurse Advice Line & Health Education Resources



cencalhealth.org/providers/patient-education-materials/nurse-advice-line/

www.cencalhealth.org/health-and-wellness/

cencalhealth.org/after-hours/

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Transportation Benefits

- Non-Medical Transportation (NMT): For members who are ambulatory needing transportation for medically covered services.
- Non-Emergency Medical Transportation (NEMT): For members who are non ambulatory needing transportation for medically covered services. Via wheelchair, gurney, ambulance, air.
  - Requires a Physician Certification Statement (PCS) Form and a Prior Authorization.
- Ventura Transit System (VTS) is CenCal Health's transportation broker.

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cencalhealth.org/providers/authorizations/

Phone Interpreting Services

Follow these quick and easy steps to connect to a telephonic interpreter in more than 200 languages:

Step 1 | DIAL

1-800-CALL-CLI or

1-800-225-5254

Step 2 | Choose Language

Provide customer code 48CEN

Provide Provider NPI & Member ID#

Step 3 | Connect

The operator will connect you promptly.

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CERTIFIED LANGUAGES INTERNATIONAL

Video Remote Interpreting Services

Your Customer Code:

→ 48CEN

Your MERFi Wed Address:

→ cencalhp.cli-video.com

Your MERFi Access Code:

→ 48cencalhp

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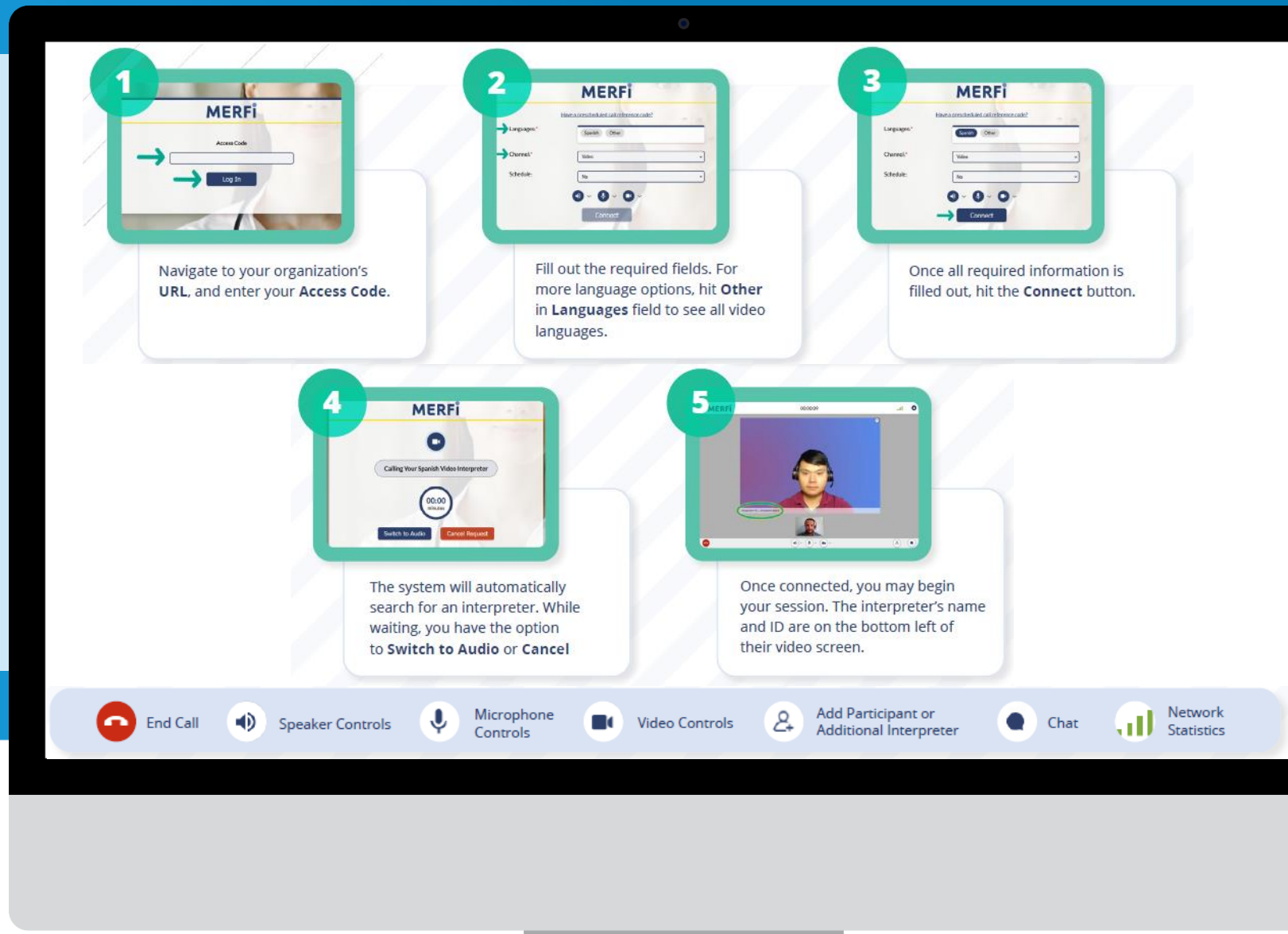

Best Practices for Providing Interpreting Services:

- It's the responsibility of the provider to request interpreter services, **not the Member** and appointments should remain scheduled
- Providers should continue to use "Voice-only" Interpreting (telephone service) whenever possible
- Avoid using family, friends or minors as interpreters
- Provider(s) should supply their own device (laptop, tablet, phone etc.) for these services. CenCal Health will not provide these devices

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- Do not use a member's phone for video or phone interpreting services
- Do not pre-schedule video interpreting services in advance as appointments may change
- Add a color or letter code to the patient's chart, noting that they need an interpreter. Designate a code or color for each language
- Add a question on your patient registration form or in your practice management system. Not only will you know when a patient is scheduled that he or she will need an interpreter, you will also be able to track how many patients you have who speak a particular language and how often they are seen.

Member Eligibility

Who, what, when, where, how

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Ways to check Eligibility

- **Online** verification on CenCal Health Provider Portal

Provider Login

- **Call** the Member Services Department
  (877) 814-1861

- Primary Care Providers, can reference their **Case Management List** on the CenCal Health Provider Portal

Additional Resources: cencalhealth.org/providers/eligibility

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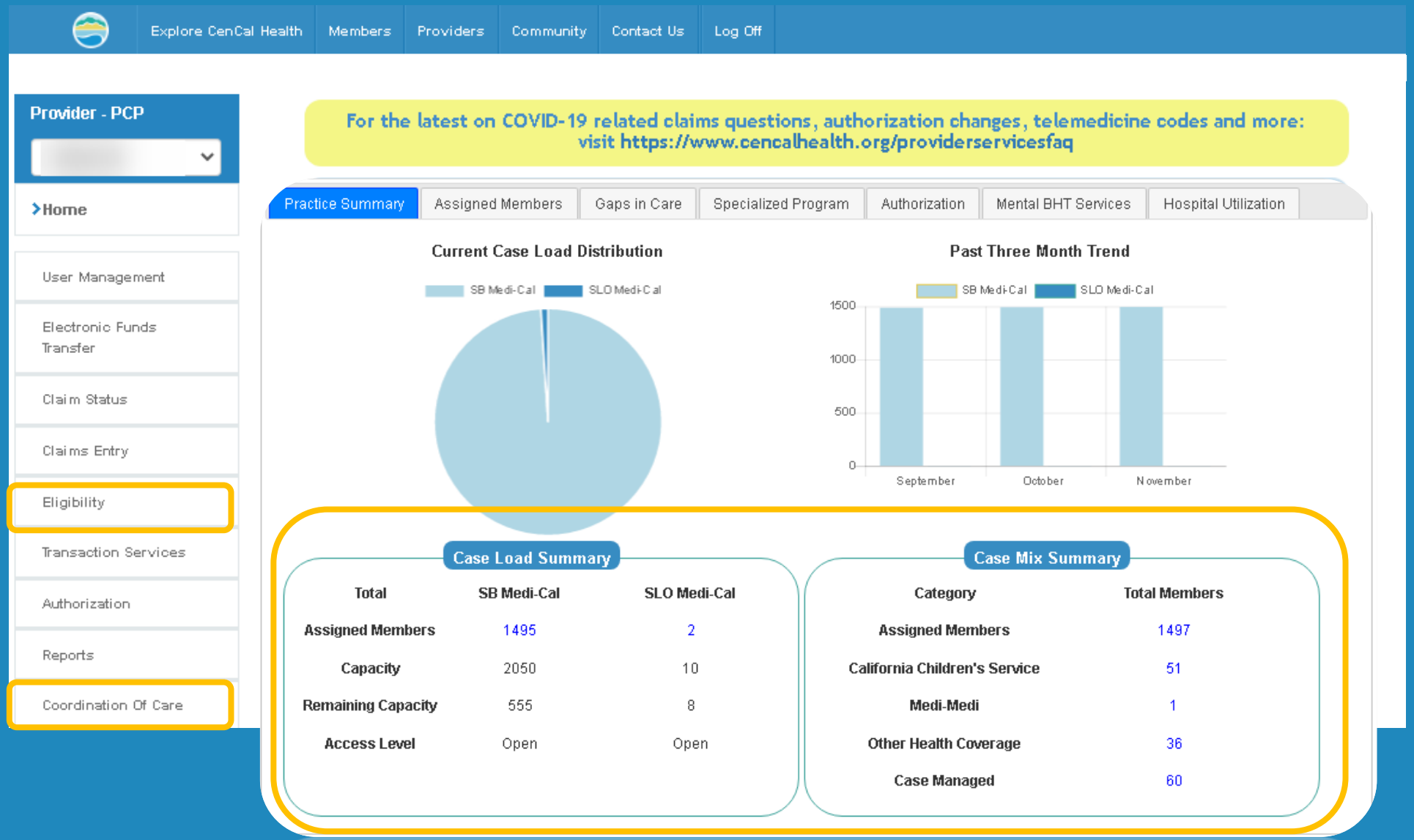
Online Portal

Staff screen permissions are managed by your Administrator, or Office Manager

Portal User Guide: Cencalhealth.org/portal/provider-portal/

Unable to see these banner permissions? Contact your Portal Administrator or email webmaster@cencalhealth.org



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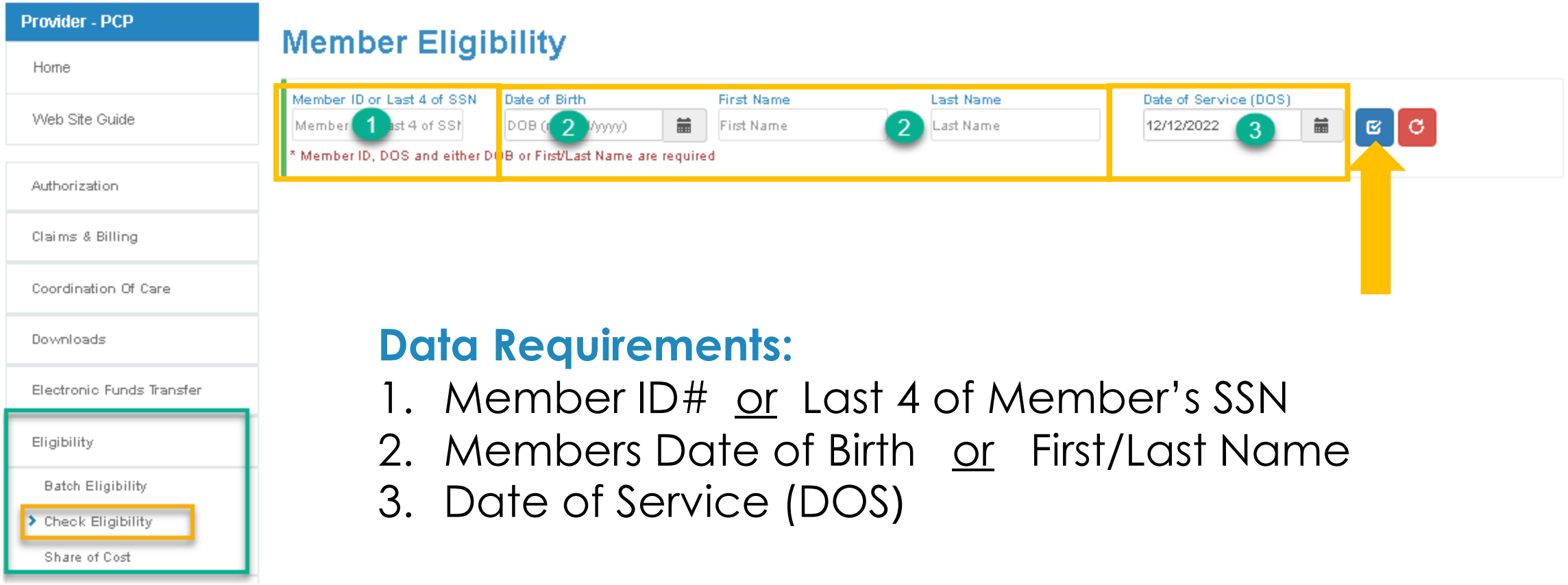
Online - Provider Portal Eligibility Check



Data Requirements:

1. Member ID# or Last 4 of Member's SSN
2. Members Date of Birth or First/Last Name
3. Date of Service (DOS)

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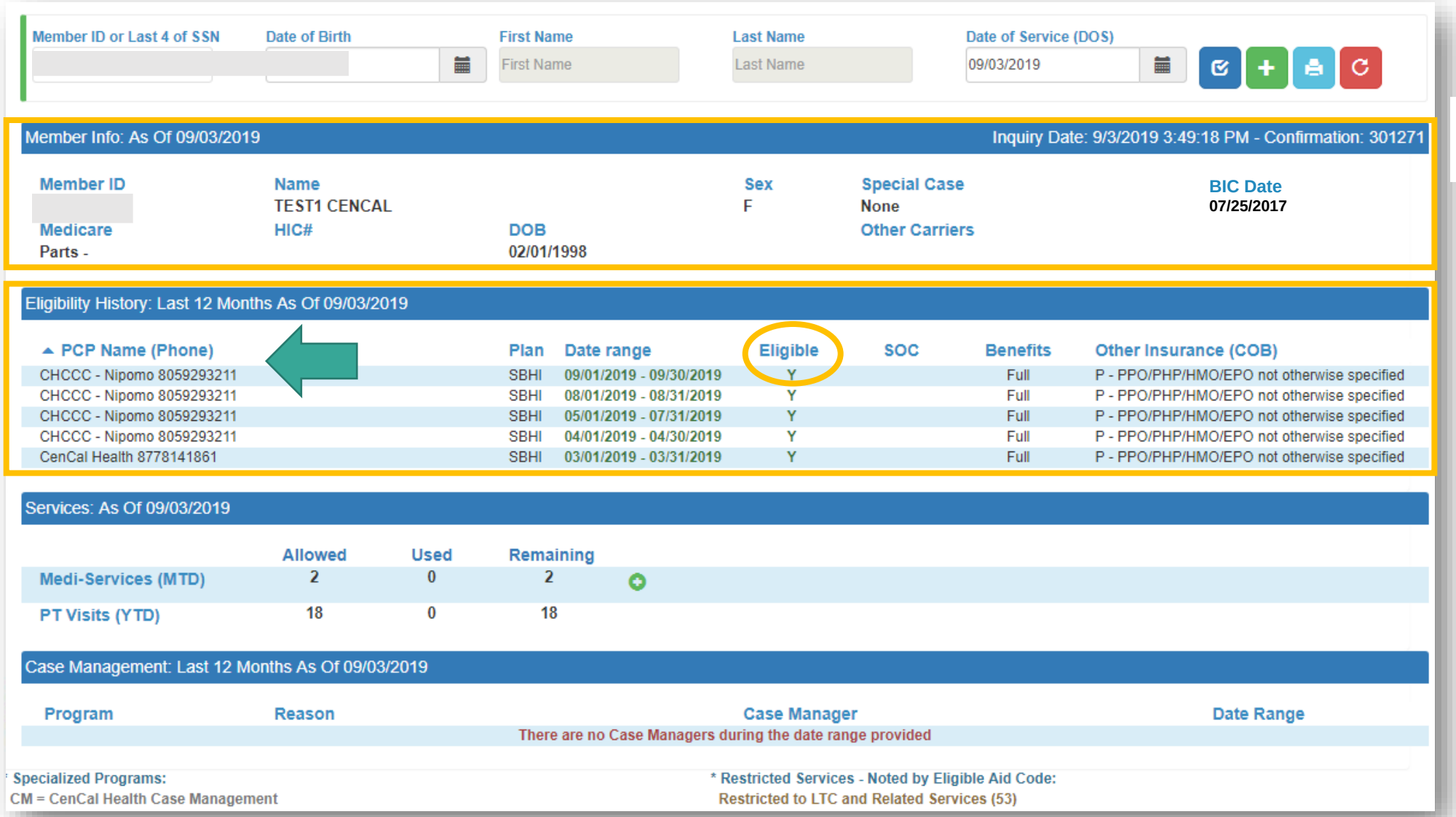
Eligible Member



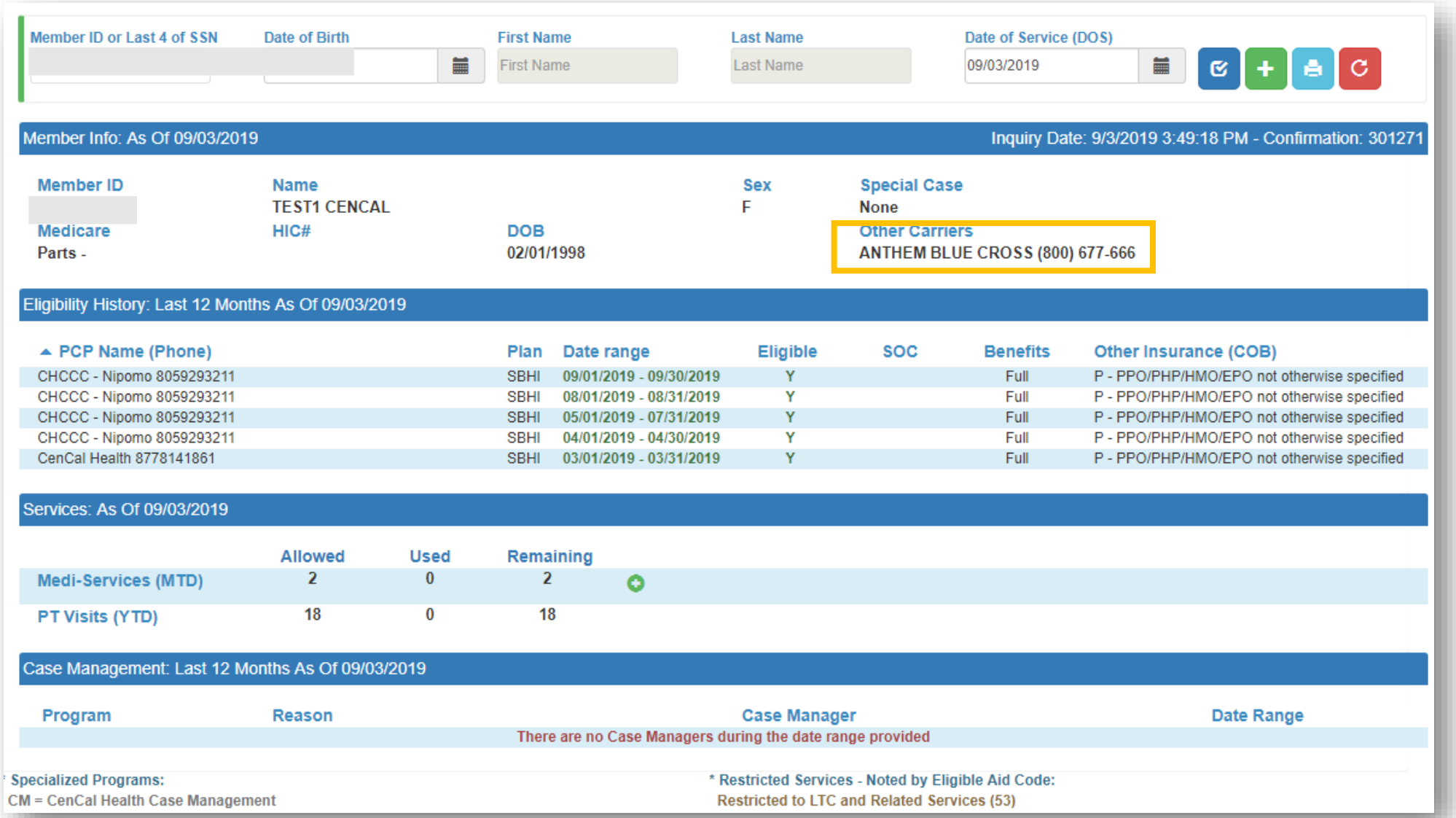
Check Eligibility

Add Member to Batch

Download to CSV

Reset Screen

Eligible Member - With Other Health Carriers



Member ID or Last 4 of SSN | Date of Birth | First Name | Last Name | Date of Service (DOS)

First Name | Last Name | 09/03/2019

Member Info: As Of 09/03/2019 — Inquiry Date: 9/3/2019 3:49:18 PM - Confirmation: 301271

Member ID	Name	Sex	Special Case
	TEST1 CENCAL	F	None

Medicare	HIC#	DOB	Other Carriers
Parts -		02/01/1998	ANTHEM BLUE CROSS (800) 677-666

Eligibility History: Last 12 Months As Of 09/03/2019

PCP Name (Phone)	Plan	Date range	Eligible	SOC	Benefits	Other Insurance (COB)
CHCCC - Nipomo 8059293211	SBHI	09/01/2019 - 09/30/2019	Y		Full	P - PPO/PHP/HMO/EPO not otherwise specified
CHCCC - Nipomo 8059293211	SBHI	08/01/2019 - 08/31/2019	Y		Full	P - PPO/PHP/HMO/EPO not otherwise specified
CHCCC - Nipomo 8059293211	SBHI	05/01/2019 - 07/31/2019	Y		Full	P - PPO/PHP/HMO/EPO not otherwise specified
CHCCC - Nipomo 8059293211	SBHI	04/01/2019 - 04/30/2019	Y		Full	P - PPO/PHP/HMO/EPO not otherwise specified
CenCal Health 8778141861	SBHI	03/01/2019 - 03/31/2019	Y		Full	P - PPO/PHP/HMO/EPO not otherwise specified

Services: As Of 09/03/2019

	Allowed	Used	Remaining
Medi-Services (MTD)	2	0	2
PT Visits (YTD)	18	0	18

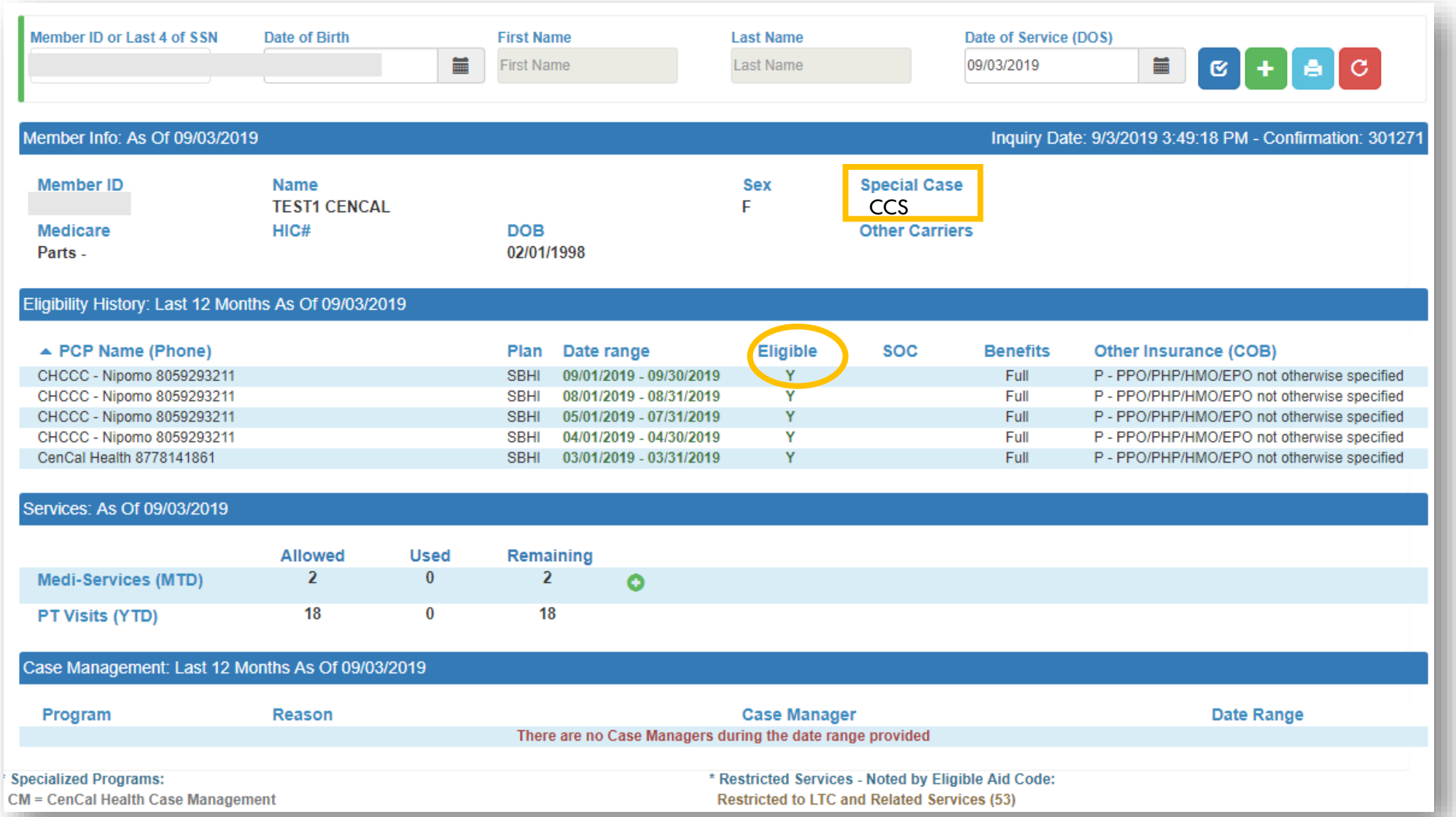
Case Management: Last 12 Months As Of 09/03/2019

Program	Reason	Case Manager	Date Range
There are no Case Managers during the date range provided			

Specialized Programs:
CM = CenCal Health Case Management

* Restricted Services - Noted by Eligible Aid Code:
Restricted to LTC and Related Services (53)

CCS Eligible Member



Member ID or Last 4 of SSN | Date of Birth | First Name | Last Name | Date of Service (DOS)

First Name | Last Name | 09/03/2019

Member Info: As Of 09/03/2019 — Inquiry Date: 9/3/2019 3:49:18 PM - Confirmation: 301271

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Medicare	HIC#	DOB	Other Carriers
Parts -		02/01/1998	

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PCP Name (Phone)	Plan	Date range	Eligible	SOC	Benefits	Other Insurance (COB)
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CHCCC - Nipomo 8059293211	SBHI	08/01/2019 - 08/31/2019	Y		Full	P - PPO/PHP/HMO/EPO not otherwise specified
CHCCC - Nipomo 8059293211	SBHI	05/01/2019 - 07/31/2019	Y		Full	P - PPO/PHP/HMO/EPO not otherwise specified
CHCCC - Nipomo 8059293211	SBHI	04/01/2019 - 04/30/2019	Y		Full	P - PPO/PHP/HMO/EPO not otherwise specified
CenCal Health 8778141861	SBHI	03/01/2019 - 03/31/2019	Y		Full	P - PPO/PHP/HMO/EPO not otherwise specified

Services: As Of 09/03/2019

	Allowed	Used	Remaining
Medi-Services (MTD)	2	0	2
PT Visits (YTD)	18	0	18

Case Management: Last 12 Months As Of 09/03/2019

Program	Reason	Case Manager	Date Range
There are no Case Managers during the date range provided			

Specialized Programs:
CM = CenCal Health Case Management

* Restricted Services - Noted by Eligible Aid Code:
Restricted to LTC and Related Services (53)

Whole Child Model (WCM) & California Children's Services (CCS)

CCS provides case management to children (0-21 years) who have serious, chronic and disabling physical conditions or diseases with special health care needs

CCS will require medical reports from a physician in order to determine eligibility and authorize services

Santa Barbara and San Luis Obispo CCS determine initial and annual eligibility (medical, residential, financial)

https://www.cencalhealth.org/providers/ccs-whole-child-model/

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Whole Child Model (WCM) & California Children's Services (CCS)

If the patient is a CenCal Health member, CCS turns the case over to CenCal Health for authorizations, Care Coordination, and Case Management

CenCal Health is billed for all of these services, and pays the approved claims

All providers that give services to our CenCal Health CCS eligible members are required to be CCS-paneled

CHILDREN'S MEDICAL SERVICES
PUBLIC HEALTH DEPARTMENT
SANTA BARBARA COUNTY
CALIFORNIA CHILDREN'S SERVICES

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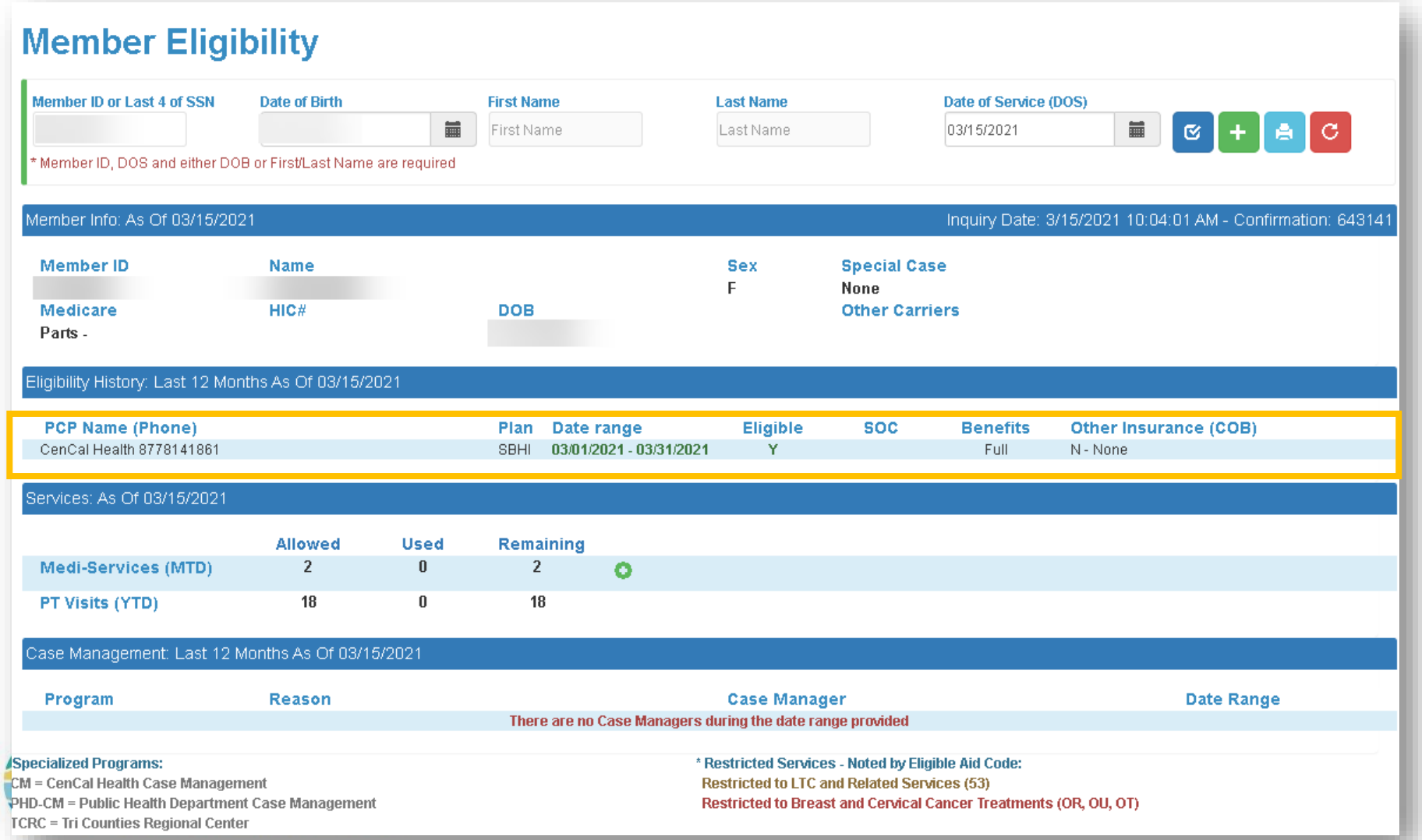
Special Class Eligible Member



Member Eligibility

Member ID or Last 4 of SSN | Date of Birth | First Name | Last Name | Date of Service (DOS)

First Name | Last Name | 03/15/2021

* Member ID, DOS and either DOB or First/Last Name are required

Member Info: As Of 03/15/2021 — Inquiry Date: 3/15/2021 10:04:01 AM - Confirmation: 643141

Member ID	Name		Sex	Special Case
			F	None
Medicare	**HIC#**	**DOB**		**Other Carriers**
Parts -				

Eligibility History: Last 12 Months As Of 03/15/2021

PCP Name (Phone)	Plan	Date range	Eligible	SOC	Benefits	Other Insurance (COB)
CenCal Health 8778141861	SBHI	03/01/2021 - 03/31/2021	Y		Full	N - None

Services: As Of 03/15/2021

	Allowed	Used	Remaining
Medi-Services (MTD)	2	0	2
PT Visits (YTD)	18	0	18

Case Management: Last 12 Months As Of 03/15/2021

Program	Reason	Case Manager	Date Range
There are no Case Managers during the date range provided			

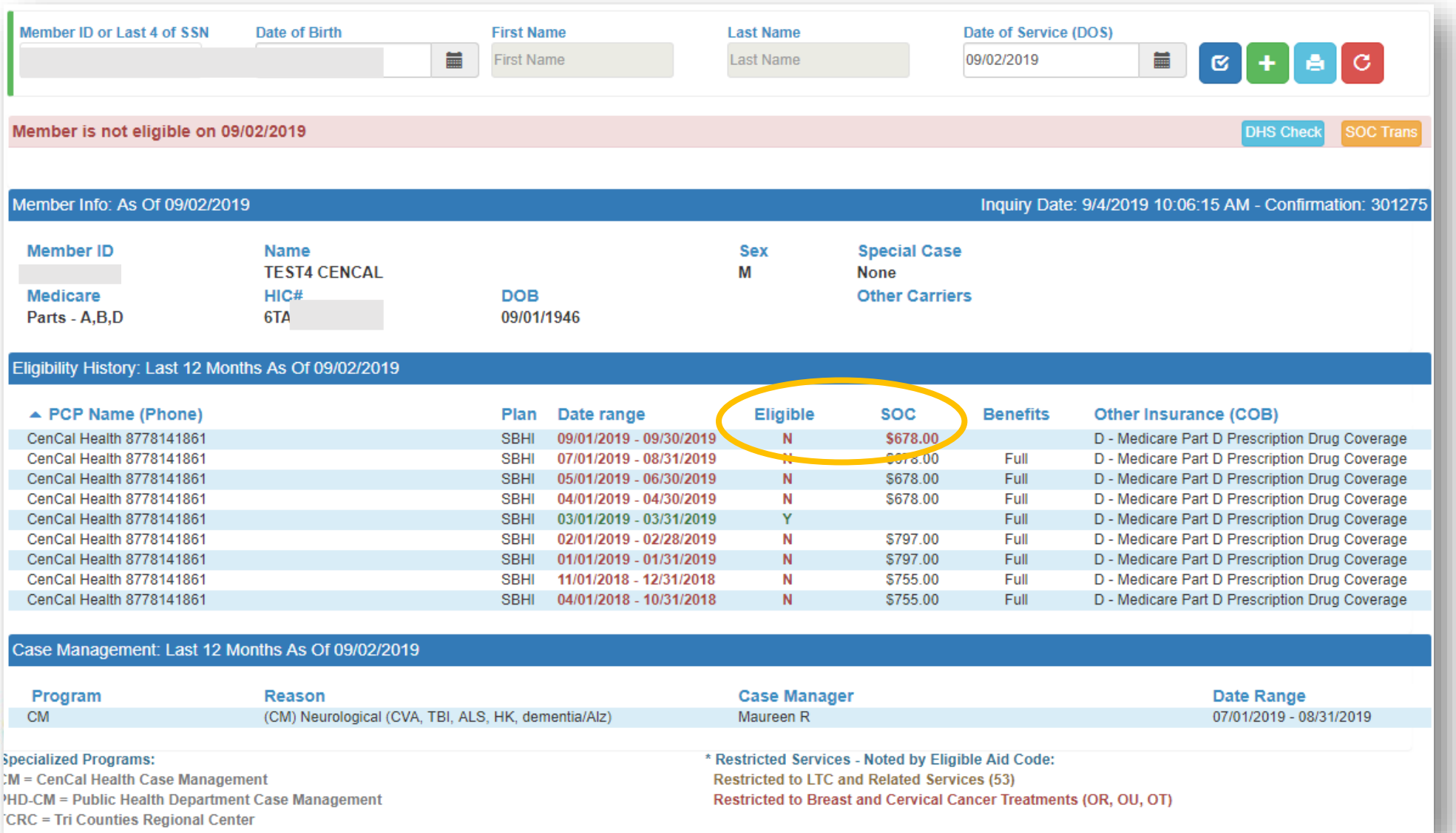
Specialized Programs:
CM = CenCal Health Case Management
PHD-CM = Public Health Department Case Management
TCRC = Tri Counties Regional Center

* Restricted Services - Noted by Eligible Aid Code:
Restricted to LTC and Related Services (53)
Restricted to Breast and Cervical Cancer Treatments (OR, OU, OT)

Special Class Categories :

- First month of eligibility with CenCal Health
- Resident in a LTC/SNF Facility
- Institutions for the developmentally disabled
- Hospice
- Are qualified under the Genetically Handicapped Persons Program (GHPP)

Member Not Eligible Share of Cost (SOC)



Member ID or Last 4 of SSN | Date of Birth | First Name | Last Name | Date of Service (DOS)

First Name | Last Name | 09/02/2019

Member is not eligible on 09/02/2019 — DHS Check | SOC Trans

Member Info: As Of 09/02/2019 — Inquiry Date: 9/4/2019 10:06:15 AM - Confirmation: 301275

Member ID	Name	Sex	Special Case
	TEST4 CENCAL	M	None

Medicare	HIC#	DOB	Other Carriers
Parts - A,B,D	6TA	09/01/1946	

Eligibility History: Last 12 Months As Of 09/02/2019

PCP Name (Phone)	Plan	Date range	Eligible	SOC	Benefits	Other Insurance (COB)
CenCal Health 8778141861	SBHI	09/01/2019 - 09/30/2019	N	$678.00		D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	07/01/2019 - 08/31/2019	N	$678.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	05/01/2019 - 06/30/2019	N	$678.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	04/01/2019 - 04/30/2019	N	$678.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	03/01/2019 - 03/31/2019	Y		Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	02/01/2019 - 02/28/2019	N	$797.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	01/01/2019 - 01/31/2019	N	$797.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	11/01/2018 - 12/31/2018	N	$755.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	04/01/2018 - 10/31/2018	N	$755.00	Full	D - Medicare Part D Prescription Drug Coverage

Case Management: Last 12 Months As Of 09/02/2019

Program	Reason	Case Manager	Date Range
CM	(CM) Neurological (CVA, TBI, ALS, HK, dementia/Alz)	Maureen R	07/01/2019 - 08/31/2019

Specialized Programs:
CM = CenCal Health Case Management
PHD-CM = Public Health Department Case Management
TCRC = Tri Counties Regional Center

* Restricted Services - Noted by Eligible Aid Code:
Restricted to LTC and Related Services (53)
Restricted to Breast and Cervical Cancer Treatments (OR, OU, OT)

Share of Cost (SOC)
To Clear or Not to Clear

SOC is a dollar amount that a member is responsible to pay on a monthly basis. The amount is established by Department of Social Services (DSS) not CenCal Health

The member must pay their SOC each month before they are eligible for CenCal benefits

If a SOC is paid to you by the patient, the amount should be spent down immediately through the portal

After the SOC is paid in full, the newly eligible CenCal member will not select a PCP, but will be made 'Special Class' for the month

Clear a Members SOC Online at www.medi-cal.ca.gov/mcwebpub/login.aspx

DHCS Telephone Service Center at 1-800-541-5555

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Eligible Member – LTC, Share of Cost & Dual Medicare Primary

Member ID or Last 4 of SSN | Date of Birth | First Name | Last Name | Date of Service (DOS)

First Name | Last Name | 09/10/2019

* Member ID, DOS and either DOB or First/Last Name are required

Member Info: As Of 09/10/2019 — Inquiry Date: 9/10/2019 1:51:33 PM - Confirmation: 3573

Member ID	Name		Sex	Special Case
				LTC

Medicare	HIC#	DOB	Other Carriers
Parts - A,B,D			

Eligibility History: Last 12 Months As Of 09/10/2019

PCP Name (Phone)	Plan	Date range	Eligible	SOC	Benefits	Other Insurance (COB)
CenCal Health 8778141861	SLOH	09/01/2019 - 09/30/2019	Y	$515.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SLOH	07/01/2019 - 08/31/2019	Y	$515.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SLOH	06/01/2019 - 06/30/2019	Y	$515.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SLOH	05/01/2019 - 05/31/2019	Y	$515.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SLOH	04/01/2019 - 04/30/2019	Y	$596.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SLOH	02/01/2019 - 03/31/2019	Y	$596.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SLOH	01/01/2019 - 01/31/2019	Y	$596.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SLOH	10/01/2018 - 12/31/2018	Y		Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SLOH	09/01/2018 - 09/30/2018	Y		Full	D - Medicare Part D Prescription Drug Coverage

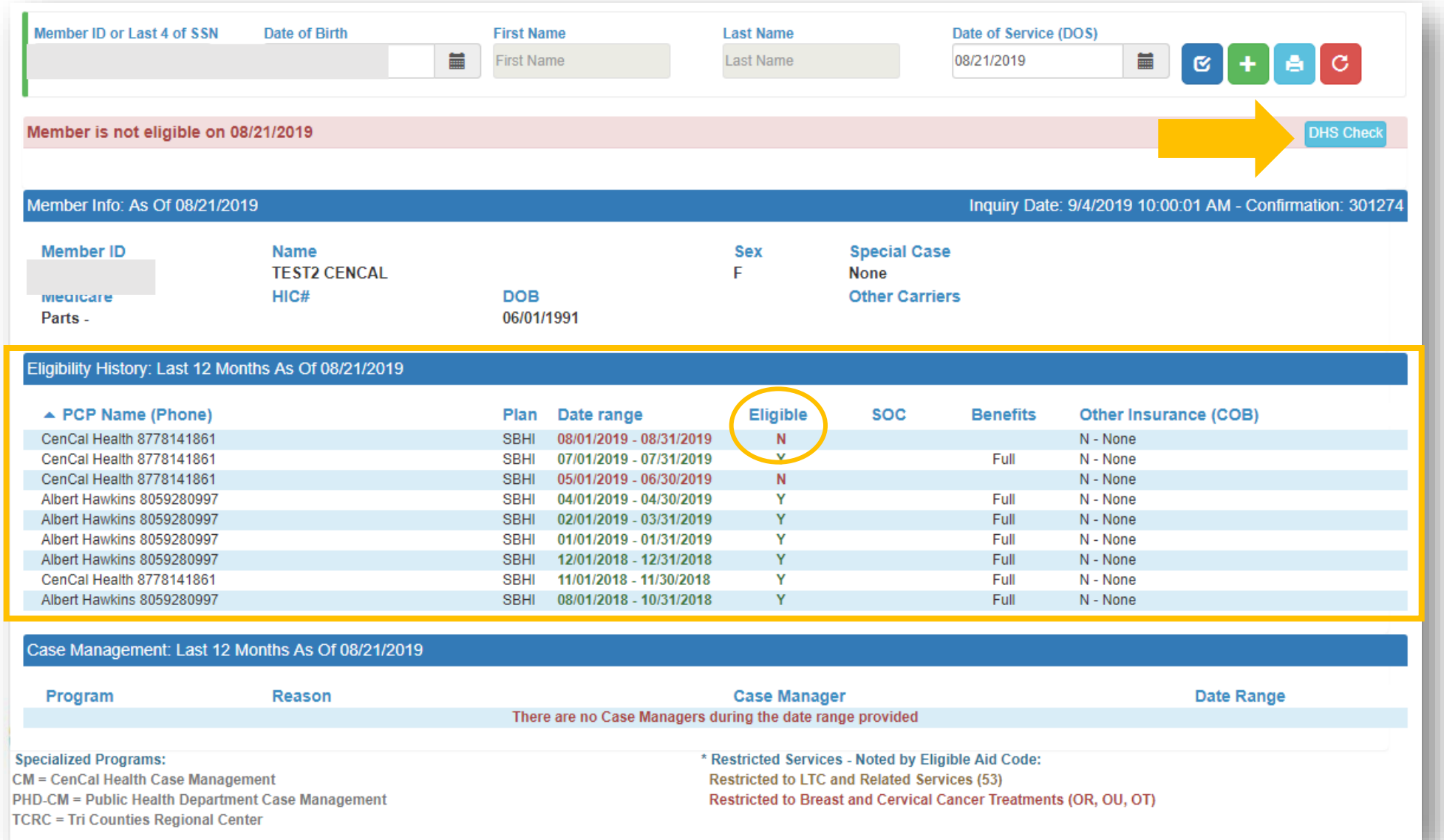
Services: As Of 09/10/2019

	Allowed	Used	Remaining
Medi-Services (MTD)	2	0	2
PT Visits (YTD)	18	0	18

Case Management: Last 12 Months As Of 09/10/2019

Program	Reason	Case Manager	Date Range
		There are no Case Managers during the date range provided	

Non Eligible Member – Check DHCS



DHS Check

DHCS Check a direct link to the States Database

Quality Care Incentive Program (QCIP) Goals & Measures

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QCIP Background

- **Launched in March 2022 to maximize the quality of care for CenCal Health membership, QCIP:**
- Is a **value-based incentive program** that directly rewards Primary Care Providers (PCPs) for the delivery of services aligned with established, evidence-based, standards of care.
- **Utilizes industry standard quality measurement** guidelines from the NCQA HEDIS® Volume 2 Technical Specifications.
- **Encourages increased utilization** of evidence-based treatment, screening, and preventative health services.
- Relies on longstanding **commitment and participation.**

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NCQA: National Committee for Quality Assurance
HEDIS: Healthcare Effectiveness Data and Information Set

QCIP Goal

Support timely identification of members due for clinically recommended aspects of care to advance health equity (e.g., cancer screenings, vaccines, well-care exams)

CenCal Health Provides:

- Monthly gaps in care reports and opportunity reports
- Best practices through a variety of forums including quality collaborative meetings, bulletins, e-blasts, and provider trainings
- Updates and reference materials available in the Provider Portal
- Health education resources for PCPs and members, including Wellness and Prevention Campaigns, the health education request line, QCIP Handouts, etc.

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QCIP Key Features

- Performance is calculated using **real-time data**
- Manual data input is not required
- Quality and timeliness of claims are reflected in quality score and payment
- **Quality Score** is based on performance for all measures combined
- **Quintile performance** is calculated as a comparison to peers

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QCIP Measures are Systematically Identified for Inclusion

Areas of needed quality improvement for CenCal Health

Feasibility of accurate quality of care measurement from claims, lab, pharmacy and registry data

Equitable distribution of adult and pediatric measures

Coverage of disease management and preventive care measures

Alignment with state-wide recommended quality focus areas

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Structure, Funding & Calculations

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Program Structure

At-Risk Funding

- PCP's capitation withhold plus CenCal Health contributions*
- Proportional to PCP caseload
- Risk-adjusted

Performance Measurement

- Calculated monthly
- No manual data entry
- Overall performance quality scores based on performance of all measures combined.

PCP Payment

- Paid quarterly
- 5-Star methodology (Quintile Performance)
- Relative to Peers

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*** CenCal Health contributions is adjusted monthly to target an overall network-wide payout**

At-Risk Funding

- An adjusted rate calculated based on both the PCP's **capitation withhold**, determined by the contractual agreement, and CenCal Health **contributions**, which account for approximately 50% of the total capitation.

- Because the at-risk funding for the program is based on capitation, the total funding available is **proportional to the PCP's caseload.**

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Performance Measurement

- **Performance calculations are processed monthly** (payments distributed quarterly) and made available through the **Provider Portal** (option to also receive this data through an SFTP in addition to being posted on the Provider Portal)
- **Measurement calculation uses NCQA-certified software** (Cotiviti) to compute how often the clinical standard of care was met
- **Requires no manual data entry.** Note that CenCal Health does incorporate supplemental administrative data not processed via claims. Examples include: registry data and EMR data files
- **The overall performance summary quality scores are based on performance for all measures combined.**

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While measures are equally weighted, measures with a larger eligible population (denominator) will be more impactful to the overall performance summary.

Payment Calculation

PCPs are stratified by their total performance (quality) score for <u>all</u> measures combined

- PCPs are ranked in descending order by aggregate performance percentage ("quality score")
- PCPs are grouped into 5 quintiles of equal size ("quintile performance")
- Each group corresponds to a number of stars earned to align with the 5-star methodology ("star rank")

★★★★★	★★★★	★★★	★★	★
5 stars = 100% *(of total at-risk funding)*	**4 stars** = 80%	**3 stars** = 60%	**2 stars** = 40%	**1 star** = 20%

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PCPs must meet a minimum threshold of 30 members in the eligible population for all measures combined; otherwise, PCPs will be credited back their capitation withhold.

Payment Expectations

Population Health will help ensure:

- Confirmation of total payment amount with the assistance of the Quality Measurement team
- Payment cover letters are posted on the Provider Portal and a hard copy is included for those receiving paper checks
- Financial summaries are reflected accurately on the Provider Portal within the QCIP dashboard
- Updates are communicated via the Provider Portal and email blast
- 1:1 assistance is provided for specific questions regarding
    - Billing codes
    - Earning potential
    - Best Practices
    - Member and Provider facing educational materials

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Investing in Quality & Effectiveness

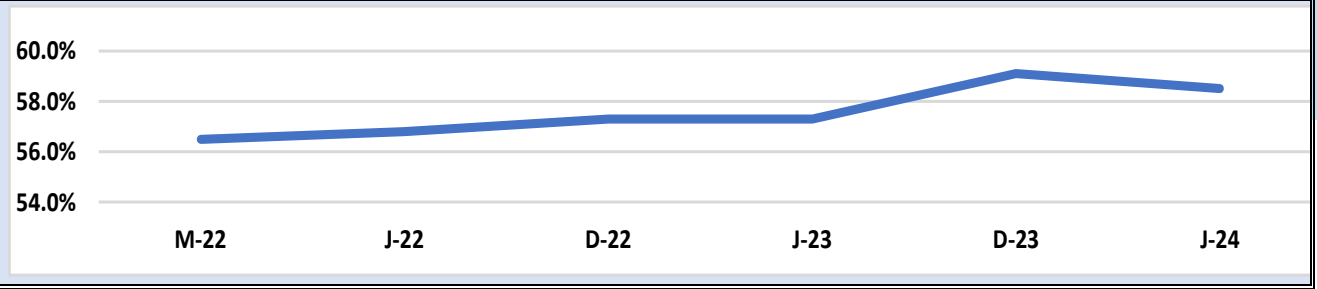
Sustainable systems change is driven by the potential for meaningful financial incentives

$35.4 million distributed since program launch in March 2022

Notable Achievements:

- antidepressant medication management
- well-child visits for infants
- pediatric lead testing
- eye exams for persons with diabetes
- chlamydia screening for women

Members that Received Timely Treatment or Preventive Services						
Clinical Categories	**Baseline Mar-22**	**Jun-22**	**Dec-22**	**Jun-23**	**Dec-23**	**Jun-24**
Behavioral Health	50.0%	50.6%	52.4%	63.5%	64.7%	66.1%
Diabetes Care	48.5%	49.9%	54.5%	53.6%	52.9%	54.5%
Pediatric Care	57.5%	57.5%	57.6%	57.8%	59.9%	58.6%
Respiratory Care	73.9%	78.2%	78.3%	70.7%	75.1%	77.5%
Women's Health	55.7%	56.1%	56.9%	56.3%	58.0%	57.7%
Overall	**56.5%**	**56.8%**	**57.3%**	**57.3%**	**59.1%**	**58.5%**



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Notable Achievements*

Percentage of Members that Received Timely Treatment or Preventive Services					
QCIP Domains of Care	Baseline (Mar-22)	Jun-24	Change	**Baseline Medicaid Percentile**	**Current Medicaid Percentile**
Behavioral Health					
Antidepressant Medication Management (Acute)	57.3%	74.0%	16.7%	**25th**	**75th**
Antidepressant Medication Management (Continuation)	42.8%	58.3%	15.5%	**33rd**	**75th**
Pediatric Care					
Lead Screening in Children	59.1%	72.9%	13.8%	**33rd**	**75th**
Well Child Visits - 2+ visits by 30 months	78.7%	81.0%	2.3%	**90th**	**90th**
Well Child Visits - 6+ visits by 15 months	50.6%	65.3%	14.7%	**25th**	**75th**
Diabetes Care					
Comprehensive Diabetes Care - Eye Exam	48.5%	54.5%	6.0%	**33rd**	**50th**
Respiratory Care					
Asthma Medication Ratio	73.9%	77.5%	3.6%	**75th**	**90th**
Women's Health					
Chlamydia Screening in Women	57.3%	62.6%	5.3%	**50th**	**67th**

***QCIP measures that had a *statistically* meaningful improvement.**

Priority & Informational Measures

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Measures encompass six domains:

1. **Behavioral Health**
2. **Cardiac Care**
3. **Diabetes Care**
4. **Pediatric Care**
5. **Respiratory Care**
6. **Women's Health**

Priority Measures

Quality measures that will be incentivized ($)

Informational Measures

Quality measures that will be reported but not incentivized

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Priority Measures

Domain	Measure	Description
Behavioral Health	Antidepressant Medication Management- Acute Treatment	The percentage of members who are 18 years and above and were diagnosed with major depression and stayed on an antidepressant for at least 12 weeks.
	Antidepressant Medication Management- Continuation Treatment	The percentage of members who are 18 years or older, have been diagnosed with major depression, and continue to take antidepressants for at least 6 months.
Women's Health	Breast Cancer Screening	The percentage of female members ages 52-74 who have received a screening mammogram in the last 24 months.
	Cervical Cancer Screening	The percentage of female members ages 24-64 who have received appropriate cervical cancer screening in the last 36 or 60 months.
	Chlamydia Screening in Women	The percentage of women ages 16-24 who are sexually active and have been screened for chlamydia in the last 12 months.
Diabetes Care	Retinal Eye Exams	The percentage of members with diabetes who have received a retinal or dilated eye exam by an optometrist or ophthalmologist in the last 12 months or a negative retinal or dilated eye exam in the last 24 months.

Priority Measures (cont.)

Domain	Measure	Description
Pediatric Care	Child & Adolescent Well Care Visits	The percentage of children ages 3-21 who have had at least one well-care visit during the last 12 months.
	Childhood Immunization Status – Influenza	The percentage of children who have received at least 2 influenza vaccinations on or before their 2nd birthday.
	Lead Testing in Children	The percentage of children who have received at least one blood lead test before their 2nd birthday.
	Well Child Visits in the First Thirty Months of Life – Before 15 months	The percentage of children who have had 6 or more well-child visits before their 15th month of age.
	Well Child Visits in the First Thirty Months of Life – 15 to 30 months	The percentage of children who have had 2 or more well-child visits before their 30th month of age.
	Immunizations for Adolescents – HPV	The percentage of adolescents who have received at least 2 HPV vaccines before their 13th birthday.
Respiratory Care	Asthma Medication Ratio	The percentage asthmatic members who have a ratio of filled controller asthma medications to total asthma medication fills of 50% or more in the last 12 months.

Area of Focus: *Pediatric Lead Exposure*

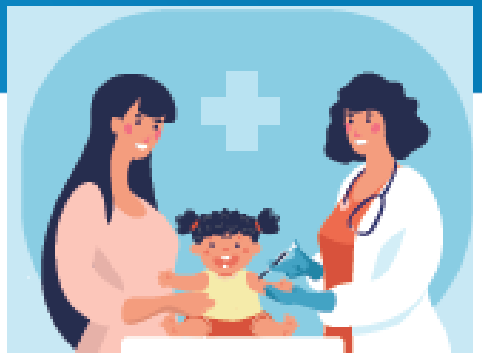
Core Components of *Lead Exposure Management*: Risk Assessment & Testing

Risk Assessment:

- Conduct lead risk assessments at **6, 9, 18, 36, 48, 60, and 72 months**, following the Bright Futures Periodicity Schedule.
- Provide appropriate follow-up for any positive risk assessments.
- Identify environmental and behavioral factors that may increase a child's risk of lead exposure.

Routine Blood Lead Testing (CPT code 83655):

- Perform blood lead testing for all children enrolled in publicly funded programs at **12 and 24 months** of age.
- Order catch-up blood testing for children up to 6 years (72 months) if testing was previously missed.



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Area of Focus: *Pediatric Lead Exposure*

Core Components of *Lead Exposure Management*: Anticipatory Guidance

Anticipatory Guidance (6 months to 6 years):

- Educate parents and caregivers about the risks and effects of lead exposure.
- Inform families about the Medi-Cal requirement for blood lead testing.
- Provide health education materials on lead screening and prevention: (e.g. *Does My Child Need a Lead Test?* pdf handout)
- Refer families to our online health library for additional resources on lead screening and testing.

Providers play a vital role in protecting children from *lead exposure* through early screening and education.

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Informational Measures

Domain	Measure	Description
Behavioral Health	Avoidance of Opioids at a High Dosage	The percentage of members who were prescribed 2 or more opioids on different dates that had less than 15 days of total opioid prescription coverage.
Cardiac Care	Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	The percentage of male members ages 21-75 and female members 40-75 with cardiovascular disease who were dispensed at least one high or moderate-intensity statin medication.
	Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80% (SPC)	the percentage of male members ages 21-75 and female members 40-75 with cardiovascular disease who remained on a high or moderate intensity statin medication for at least 80% of the treatment period.
Diabetes	Statin Therapy for Patients with Diabetes - Received Statin Therapy (SPD)	The percentage of members ages 40-75 with diabetes who were dispensed at least one statin medication during the year.
	Statin Therapy for Patients with Diabetes - Statin Adherence 80% (SPD)	The percentage of members ages 40-75 with diabetes who remained on a statin medication for at least 80% of the treatment period

Informational Measures (cont.)

Domain	Measure	Description
Pediatric Care	Immunizations for Adolescent- Combo 2	Percentage of adolescents who have received at least 1 Tdap, 1 Meningococcal, and at least 2 human papillomavirus (HPV) vaccines before their 13th birthday
	Immunizations for Adolescents – Meningococcal	The percentage of adolescents who have received at least 1 Meningococcal vaccine before their 13th birthday.
	Developmental Screening in the First Three Years of Life (DEV) **(Priority starting Q3-2025)**	Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their 1st, 2nd, or 3rd birthday.
	Topical Fluoride for Children (TFL) **(Priority starting Q3-2025)**	Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications within the measurement year.
Respiratory Care	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid (PCE)	The percentage of members with COPD 40 and older who had an ED visit and were dispensed a systemic corticosteroid.
	Pharmacotherapy Management of COPD Exacerbation Bronchodilator (PCE)	The percentage of members with COPD 40 and older who had an emergency department (ED) visit and were dispensed a bronchodilator.

Provider Portal

Contains a variety of reports available within the Quality Care Incentive Program Tab found on the far left of the portal screen

- Financial & Performance Overview
- Forms and Resources (e.g., cover letters & measure updates)
- Additional Opportunity Reports to assist with pediatric outreach (e.g., lead testing, well baby exams)

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Performance Report

QCIP Performance - Provider Summary Sample

Provider Summary by Measure								
PCP	Domain*	Measure	Members in Measure	*Met**	*Not Met**	Rate	Variance	CenCal Rate
	Diabetes Care	Comprehensive Diabetes Care - Eye Exam	2	0	2	0.00%	-53.82%	53.82%
	Diabetes Care - Summary		**2**	**0**	**2**	**00.00%**	**-53.82%**	**53.28%**
	Pediatric Care	Child and Adolescent Well-Care Visits	2,333	1,522	811	65.24%	9.71%	55.53%
		Childhood Immunization Status - Influenza	162	84	78	51.85%	-5.80%	57.65%
		Immunizations for Adolescents - Combination 2	136	33	103	24.26%	-20.48%	44.75%
		Immunizations for Adolescents - HPV	136	33	103	24.26%	-23.00%	47.26%
		Immunizations for Adolescents - Meningococcal	136	89	47	65.44%	-16.62%	82.06%
		Immunizations for Adolescents - Tdap	136	119	17	87.50%	-3.17%	90.67%
		Lead Screening in Children	162	60	102	37.04%	-25.88%	62.92%
		Well Child Visits in the First Thirty Months of Life - 2 or more visits before their 30th month of age	179	143	36	79.89%	0.35%	79.54%
		Well Child Visits in the First Thirty Months of Life - 6 or more visits before their 15th month of age	121	83	38	68.60%	9.09%	59.51%

**Verbiage on individual report may differ*

Opportunity Reports

- **Well-Child Visits in the First 15 months of Life**
- **Pediatric Lead Testing**

Member First Name	Member Last Name	Member DOB	Member Age (MON)	Subscriber First Name	Subscriber Last Name	Home Phone	Address	City	State	Zip	Language	Qualified Visits Date	Qualified Visits	Behind Schedule	Remaining Visits	Date Member Turn 15 Mos
		/2022	14.58					SN LUIS OBISP	CA		English	12/22/2022; 01/23/2023; 03/28/2023; 05/30/2023; 10/03/2023; 01/16/2024	6	N	0	3/14/2024
		2023	7.00					SN LUIS OBISP	CA		English	10/02/2023; 12/11/2023; 02/14/2024	3	N	3	11/1/2024
		2023	10.25					SANTA MARIA	CA		English	06/05/2023; 11/20/2023; 03/11/2024	3	Y	3	7/24/2024
		2023	11.35				H	ATASCADERO	CA		English	03/23/2023; 04/25/2023; 06/26/2023; 12/28/2023	4	Y	2	6/21/2024

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Mental Health Benefit & Eligibility: Non-Specialty Mental Health Services

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Mental Health Benefit

Mental health services are a covered benefit and may be provided by:

- A Primary Care Physician
- A mental health practitioner employed by a CenCal Health contracted FQHC
- A mental health practitioner contracted with the CenCal Health

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Mental Health Benefit: Non-Specialty Mental Health Services

CenCal Health covers Non-Specialty Mental Health Services, which include:

- Mental health evaluation and treatment including individual, group, and family psychotherapy and dyadic behavioral health services
- Psychological and neuropsychological testing
- Outpatient services for the purpose of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies, and supplements

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Mental Health Benefit-Carve Out

Level of Impairment	**Mild**	**Moderate**	**Severe**
Benefit	Non-Specialty Mental Health Services	Non-Specialty Mental Health Services	**Specialty Mental Health Services (SMHS)**
MCP/MHP	CenCal Provider	CenCal Provider	**County Provider**

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Eligibility Criteria

Members who meet the following criteria are eligible:

- Members aged 21 years and over with ***mild to moderate distress*** or ***impairment*** from a mental health disorder.
- Members under the age of 21, to the extent otherwise eligible for services through **EPSDT**, regardless of level of distress or impairment or the presence of a diagnosis
- Members of any age with potential mental health disorders not yet diagnosed

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Mental Health Referral and Authorization

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Referral and Authorization

The following Mental Health services require preauthorization:

- Psychological Testing
- Neuropsychological Testing

The following Mental Health services are open access for members:

- Psychotherapy
- Medication Management

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Mental Health Open Access

Members may be referred to therapy or psychiatry:

1

Contacting the Behavioral Health Call Center at (800) 421-2560 to obtain names and numbers of available providers.

2

Referred to the provider directory at CenCalHealth.org to find an available mental health provider.

3

Providers may complete a Behavioral Health Care Coordination Form and submit to the Behavioral Health Department for outreach and assistance to obtain an appointment with a contracted provider.

Mental Health Access: Eating Disorder Treatment

Eligible CenCal Health Members who are determined to meet medical necessity have the following **covered benefits with CenCal Health:**

- Partial Hospitalization
- Residential Treatment

Eligible CenCal Health Members who are determined to meet medical necessity have the following **covered benefits with the County Mental Health Plan:**

- In Patient Psychiatric Hospitalization
- Intensive Outpatient Programs

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Mental Health Access:
Eating Disorder Treatment Referral

- To refer a member to medical case management, please complete the Case Management Referral Form.
- To refer a member for behavioral health care coordination for a suspected or diagnosed Eating Disorder, please complete the Eating Disorder Treatment Referral Form.
- To refer a member to a specialist, including a registered dietician for nutritional counseling and monitoring please complete the Referral Form.

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Referral and Authorization: Psychological and Neuropsychological Testing

Physicians who recommend Psychological or Neuropsychological Testing, should refer a member to a contracted Psychologist (No REFERRAL Required):

1. Identify and Consult with a contracted psychologist.
   - Please see the PCP Psychological Evaluation Request form.

2. Assist or direct the member to schedule an appointment.

3. The psychologist will meet with the member and evaluate if testing is medically necessary and share their clinical recommendations with the referring physician.

4. The psychologist will submit an authorization for testing to CenCal Health, if testing is clinically indicated.

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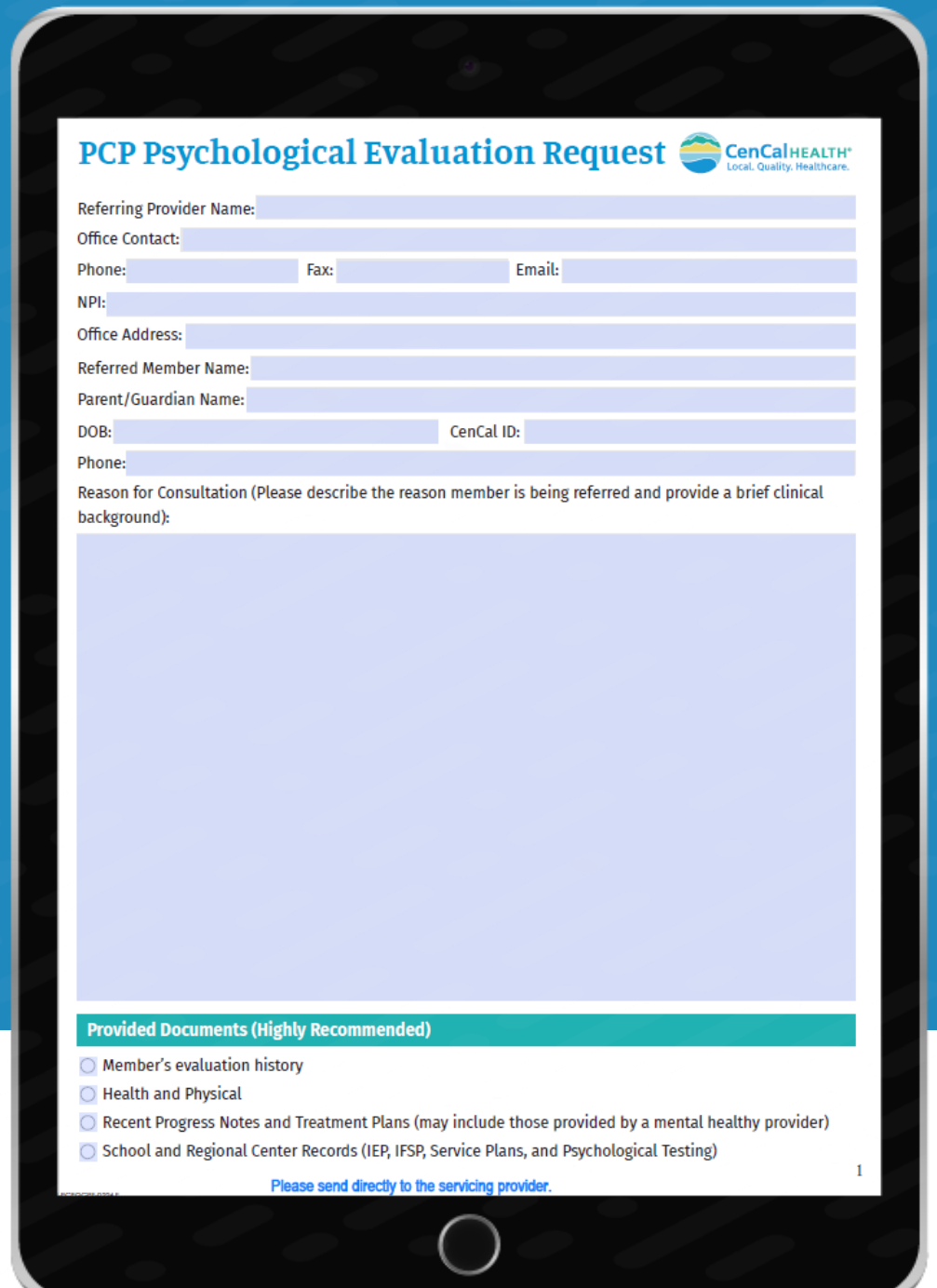
PCP Psychological Evaluation Request



PCP Psychological Evaluation Request

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Referring Provider Name:

Office Contact:

Phone: Fax: Email:

NPI:

Office Address:

Referred Member Name:

Parent/Guardian Name:

DOB: CenCal ID:

Phone:

Reason for Consultation (Please describe the reason member is being referred and provide a brief clinical background):

Provided Documents (Highly Recommended)

- ○ Member's evaluation history
- ○ Health and Physical
- ○ Recent Progress Notes and Treatment Plans (may include those provided by a mental healthy provider)
- ○ School and Regional Center Records (IEP, IFSP, Service Plans, and Psychological Testing)

1

Please send directly to the servicing provider.

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Mental Health Screenings

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Depression Screenings

Primary Care Physicians:

- 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.
- 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.

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Validated Screenings

Primary Care Physicians:

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

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

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)

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For a comprehensive list of validated screening tools, please see the Provider Manual.

Billing Codes

Primary Care Physicians may use the following codes:

- G8431, Screening for Depression, Positive Result and Provision of Recommendations Provided.
- G8510, Screening for Depression, Negative Result
- H0050 Alcohol and/or drug services, brief intervention, per 15 minutes

Practitioners certified to complete ACE screenings may use the following codes:

- G9919, Positive and Provisions of Recommendations Provided (ACE score 4+)
- G9920, Screening performed and results negative (ACE score 0 to 3)

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Screening Referral

- 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.
- Members may also be referred to Case Management Services.

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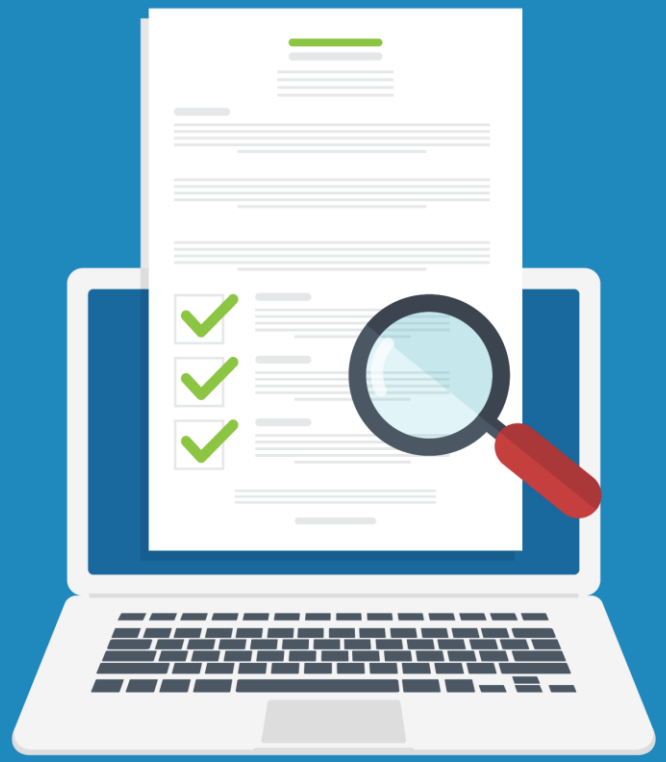
Screening Documentation Requirements

Providers must document all of the following:

- The screening tool that was used,
- That the completed screen was reviewed,
- The results of the screening,
- The interpretation of results; and
- What was discussed with the member and/or family, and any appropriate actions taken.



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Specialty Mental Health Services – A Carve Out Benefit

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Specialty Mental Health Services

Specialty Mental Health Services are covered by the County Mental Health Plan.

Members who meet criteria for Specialty Mental Health Services may be referred to the county directly or CenCal Health Behavioral Health Department for care coordination.

- *PCP Providers, please use the Behavioral Health Care Coordination Form.*

Both available on the Mental Health and Behavioral Health Treatment Provider webpage .

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Specialty Mental Health Services

Specialty Mental Health Services are carved out to the County Mental Health Plan.
Members must meet the criteria 1 and 2 below:

Criterion 1: The member has on or both of the following:

- Significant impairment, where impairment is defined as distress, disability or dysfunction in an important area of life.
- A reasonable probability or significant deterioration in an important are of life.

Criterion 2: The member's condition in criterion 1 is due to the either of the following:

- A diagnosed mental health disorder.
- A suspected mental health disorder that has not yet been diagnosed.

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Specialty Mental Health Services

Members under 21 year of age must meet EITHER criteria 1 and 2 below:

Criterion 1: The member 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 an approved trauma screening tool
- Involvement in the child welfare system
- Juvenile justice involvement
- Experiencing homelessness

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Specialty Mental Health Services

Members under 21 year of age must meet EITHER criteria 1 and 2 below:

Criterion 2: The recipient meets both requirements A and B:

A. The member 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 impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

B. The member's condition in requirement A above is due to at least one of the following:

- A diagnosed mental health disorder, according to the criteria of the current edition of the DSM.
- A suspected mental health disorder that has not yet been diagnosed
- Significant trauma placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

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Coordinated Mental Health Benefits

When a member meets criteria for both Non-Specialty and Specialty Mental Health services, the member should receive services based on:

- Individual need
- Established therapeutic relationship
- Coordination and not duplicative

For example, a member may receive psychiatry services from CenCal but not form the County at the same time. Such decisions should be made via a patient-centered shared decision-making process.

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Substance Use Benefit

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Substance Use Treatment

Substance use treatment services remain a carve-out benefit to the County.

- Detox (social model)
- Medication Assisted Treatment
- Outpatient Services
- Dual Diagnosis Programs
- IOP
- Residential

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Substance Use Benefit-SABIRT

Primary Care Providers are responsible to provide all preventive services for members

- Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.
- Services may be provided by providers within their scope of practice and must comply with laws and regulations relating to the privacy of SUD including state law concerning the right of minors over 12 years of age.

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SABIRT Validated Screening Tools

Primary Care Providers approved screening tools:

- 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 o The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening
- 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 geriatric population.

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SABIRT Validated Assessment Tools

Primary Care Providers approved brief assessment tools:

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

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SABIRT Brief Interventions and Referrals

Brief interventions 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; and
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

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SABIRT Brief Interventions and Referrals

For individuals requiring alcohol and Substance Use Disorder Treatment, providers must arrange their referral to:

- County for Alcohol and Drug treatment programs;
- Community resources when services are not available through the county;
- Outpatient heroin detoxification providers that are available through Medi-Cal fee-for-service program, for appropriate services.

Providers may refer Members to the Behavioral health Department for care coordination.

Please complete the Behavioral Health Care Coordination Form

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SABIRT Documentation Requirements

Documentation Requirements Member medical records must include the following:

- The service provided (e.g., 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); and
- If and where a referral to an AUD or SUD program was made.

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SABIRT Billing

Primary Care Physicians may use the following codes:

- G0042 Alcohol Screening
- H0049 Drug Use Screening
- H0050 Brief Interventions for Alcohol and/or Drug Use

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Behavioral Health Treatment Benefit & Eligibility

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Behavioral Health Treatment (ABA) Benefit

CenCal Health covers Behavioral Health Treatment (BHT) for individuals under the age of 21 in accordance with DHCS EPSDT guidelines.

Behavioral Health Treatment services may include but is not limited to Applied Behavior Analysis (ABA), behavioral interventions and parent training.

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Behavioral Health Treatment (ABA) Eligibility

A member may qualify for Behavioral Health Treatment Services if all of the following criteria are met:

- Under 21 years of age consistent with EPSDT guidelines
- Medically Stable
- Not in need of 24-hour nursing
- Not in an Intermediate Care Facility

The Member has a recommendation that BHT services are medically necessary by a Physician, Psychologist or Surgeon.

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Recommendation

Providers who recommend BHT services as medically necessary should submit a:

- Completed **BHT Recommendation Form** to the Behavioral Health Department.

Consistent with All Plan Letter 20-010, Responsibilities of Behavioral Health Treatment Coverage for Members Under the Age of 21:

- An Autism Spectrum Disorder diagnosis is not required
- A Comprehensive Developmental Evaluation is not required.

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QCIP Behavioral Health Measure Reminder

Priority: Quality measures that will be incentivized ($)
Informational Only: Quality measures that will be reported but not incentivized.

Category	Measure Title	Measure Description	Incentive Eligible
Behavioral Health	Antidepressant Medication Management - Acute Treatment	The percentage of members age 18 and older who were diagnosed with major depression and remained on an antidepressant for at least 12 weeks.	$
	Antidepressant Medication Management - Continuing Treatment	The percentage of members age 18 and older who were diagnosed with major depression and remained on an antidepressant for at least 6 months.	$
	Avoidance of Opioids at a High Dosage	The percentage of members who were prescribed 2 or more opioids on different dates that had less than 15 days of total opioid prescription coverage.	Information Only

- G8431: Screening for depression is documented as positive and a follow-up plan is documented
- G8510: Screening for depression is documented as negatives, a follow-up plan is not required

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cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

Behavioral Health & Mental Health Online Resources and Forms

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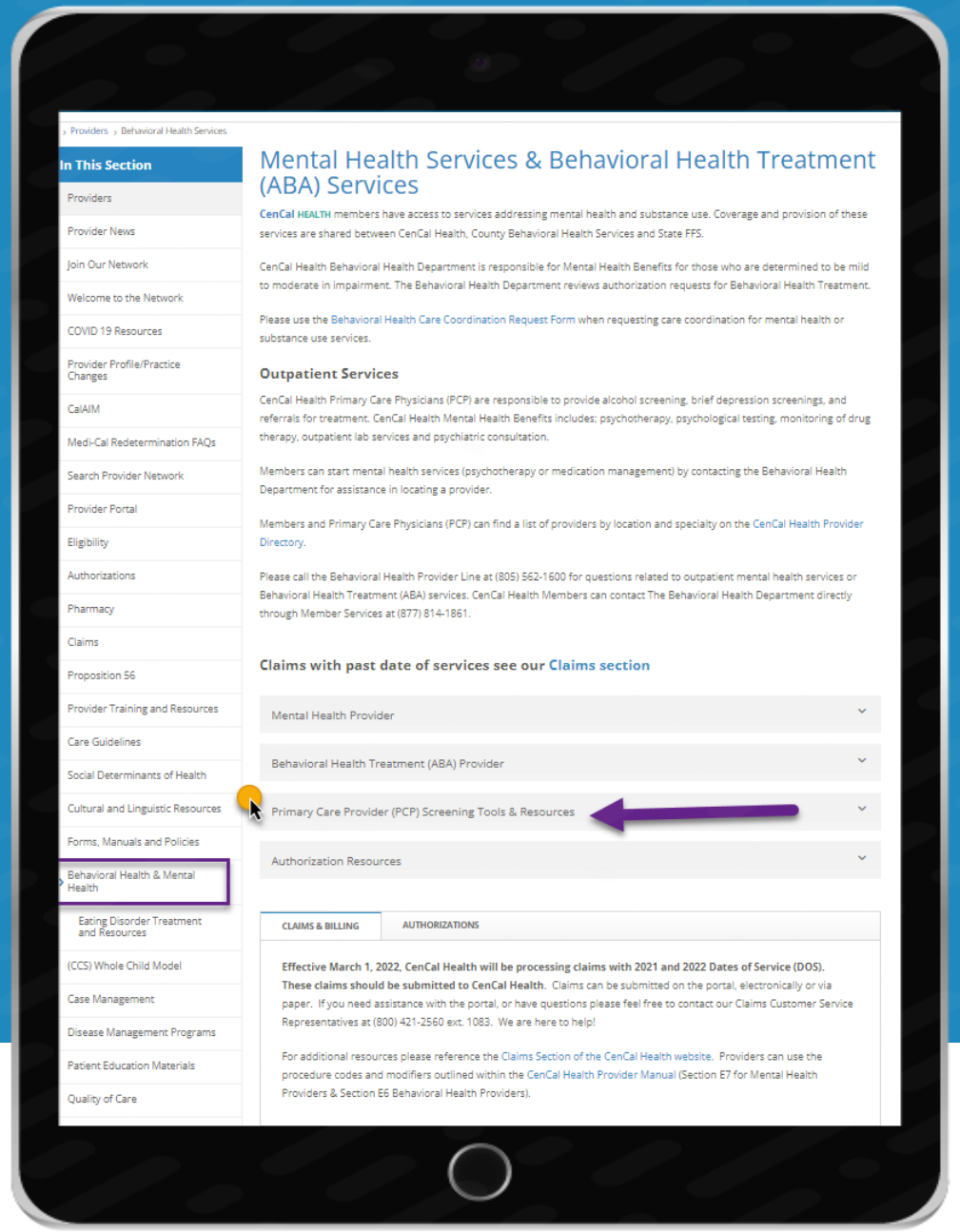
Online Mental Health Provider Resources

cencalhealth.org/providers/forms-manuals-policies/forms-library/



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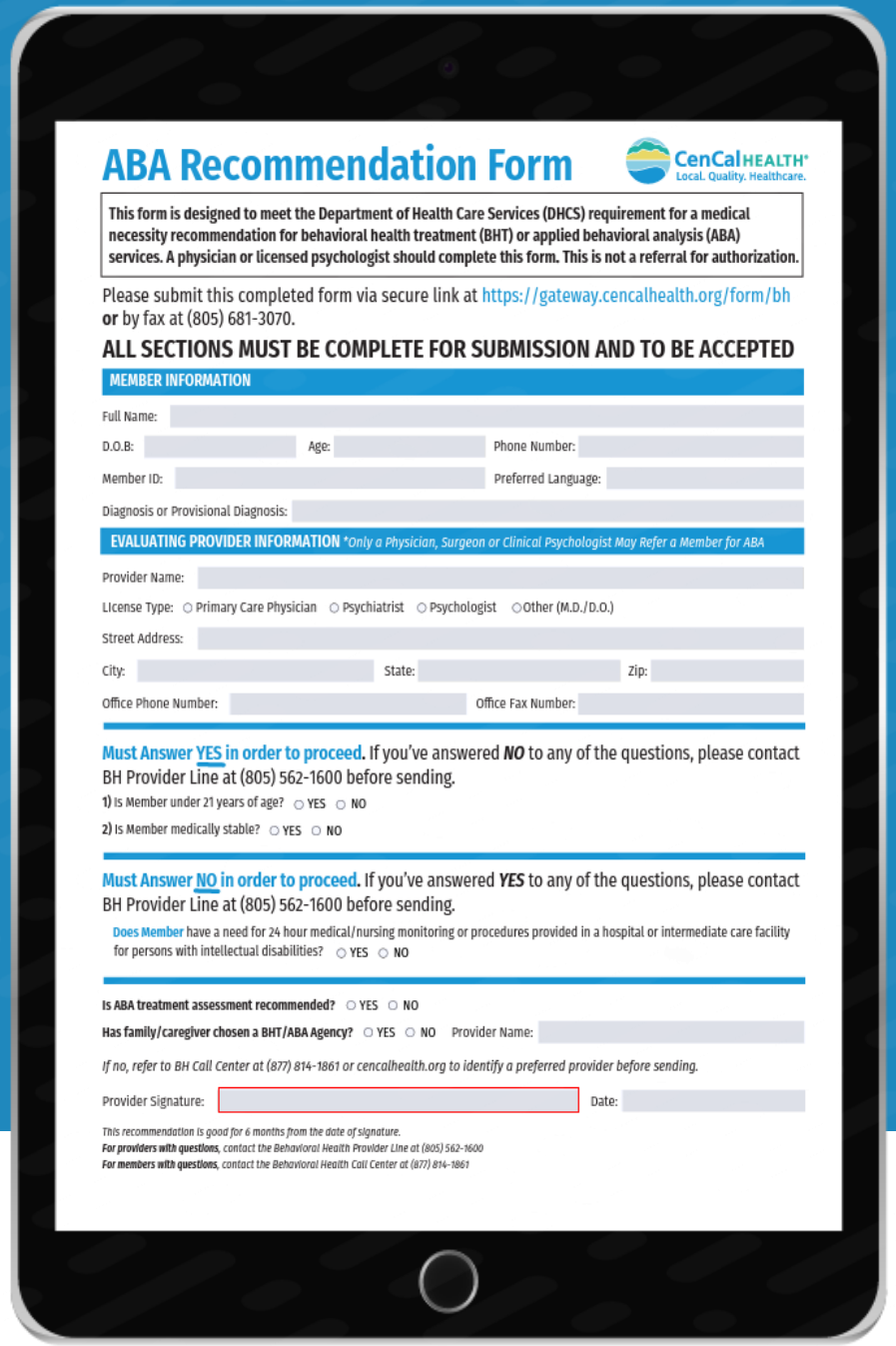
Behavioral Health ABA Recommendation Form

cencalhealth.org/providers/forms-manuals-policies/forms-library/



ABA Recommendation Form

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This form is designed to meet the Department of Health Care Services (DHCS) requirement for a medical necessity recommendation for behavioral health treatment (BHT) or applied behavioral analysis (ABA) services. A physician or licensed psychologist should complete this form. This is not a referral for authorization.

Please submit this completed form via secure link at https://gateway.cencalhealth.org/form/bh **or** by fax at (805) 681-3070.

ALL SECTIONS MUST BE COMPLETE FOR SUBMISSION AND TO BE ACCEPTED

MEMBER INFORMATION

Full Name:

D.O.B: Age: Phone Number:

Member ID: Preferred Language:

Diagnosis or Provisional Diagnosis:

EVALUATING PROVIDER INFORMATION **Only a Physician, Surgeon or Clinical Psychologist May Refer a Member for ABA*

Provider Name:

License Type: ○ Primary Care Physician ○ Psychiatrist ○ Psychologist ○ Other (M.D./D.O.)

Street Address:

City: State: Zip:

Office Phone Number: Office Fax Number:

Must Answer YES in order to proceed. If you've answered ***NO*** to any of the questions, please contact BH Provider Line at (805) 562-1600 before sending.

1) Is Member under 21 years of age? ○ YES ○ NO

2) Is Member medically stable? ○ YES ○ NO

Must Answer NO in order to proceed. If you've answered ***YES*** to any of the questions, please contact BH Provider Line at (805) 562-1600 before sending.

Does Member have a need for 24 hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities? ○ YES ○ NO

Is ABA treatment assessment recommended? ○ YES ○ NO

Has family/caregiver chosen a BHT/ABA Agency? ○ YES ○ NO Provider Name:

If no, refer to BH Call Center at (877) 814-1861 or cencalhealth.org to identify a preferred provider before sending.

Provider Signature: Date:

This recommendation is good for 6 months from the date of signature.
***For providers with questions**, contact the Behavioral Health Provider Line at (805) 562-1600*
***For members with questions**, contact the Behavioral Health Call Center at (877) 814-1861*

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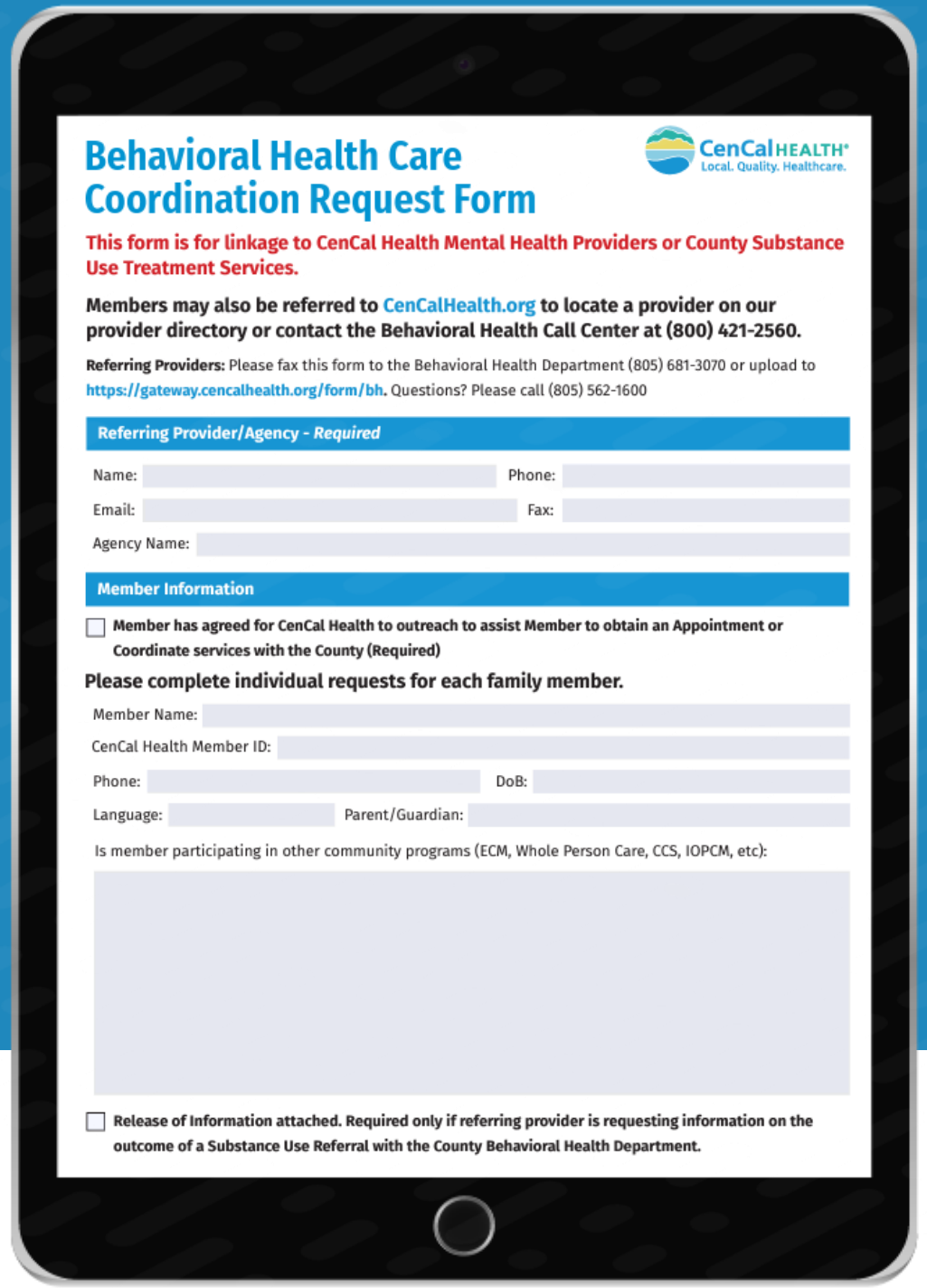
Behavioral Health Care Coordination Request Form

cencalhealth.org/providers/forms-manuals-policies/forms-library/



Behavioral Health Care Coordination Request Form

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This form is for linkage to CenCal Health Mental Health Providers or County Substance Use Treatment Services.

Members may also be referred to CenCalHealth.org to locate a provider on our provider directory or contact the Behavioral Health Call Center at (800) 421-2560.

Referring Providers: Please fax this form to the Behavioral Health Department (805) 681-3070 or upload to https://gateway.cencalhealth.org/form/bh. Questions? Please call (805) 562-1600

Referring Provider/Agency - *Required*

Name: Phone:

Email: Fax:

Agency Name:

Member Information

☐ **Member has agreed for CenCal Health to outreach to assist Member to obtain an Appointment or Coordinate services with the County (Required)**

Please complete individual requests for each family member.

Member Name:

CenCal Health Member ID:

Phone: DoB:

Language: Parent/Guardian:

Is member participating in other community programs (ECM, Whole Person Care, CCS, IOPCM, etc):

☐ **Release of Information attached. Required only if referring provider is requesting information on the outcome of a Substance Use Referral with the County Behavioral Health Department.**

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Member Eating Disorder Treatment & Resources

cencalhealth.org/members/behavioral-health/eating-disorder-treatment-and-resources/

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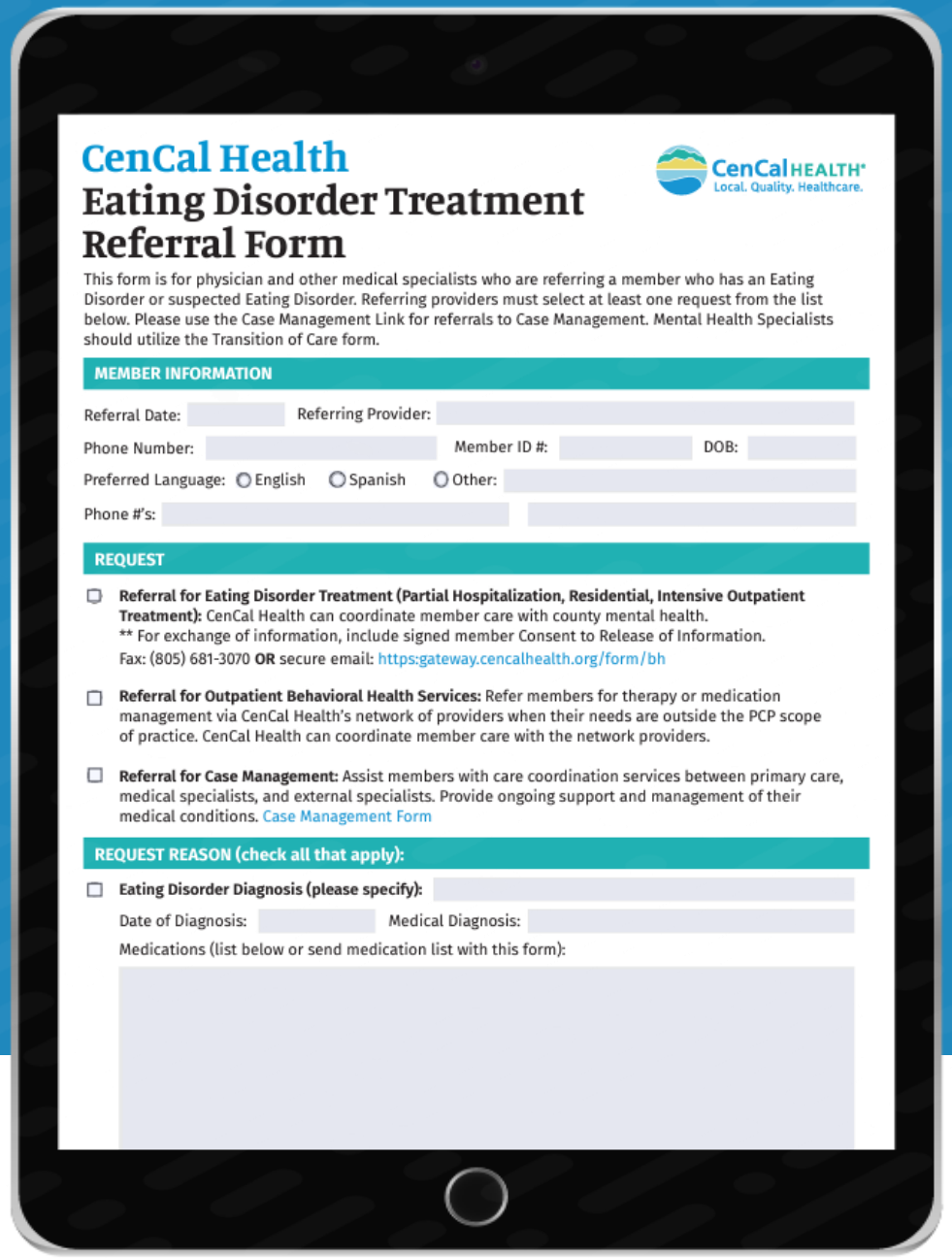
Eating Disorder Treatment Referral Form

cencalhealth.org/providers/eating-disorder-treatment-and-resources/



CenCal Health

Eating Disorder Treatment Referral Form

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This form is for physician and other medical specialists who are referring a member who has an Eating Disorder or suspected Eating Disorder. Referring providers must select at least one request from the list below. Please use the Case Management Link for referrals to Case Management. Mental Health Specialists should utilize the Transition of Care form.

MEMBER INFORMATION

Referral Date: Referring Provider:

Phone Number: Member ID #: DOB:

Preferred Language: ○ English ○ Spanish ○ Other:

Phone #'s:

REQUEST

☐ **Referral for Eating Disorder Treatment (Partial Hospitalization, Residential, Intensive Outpatient Treatment):** CenCal Health can coordinate member care with county mental health.
** For exchange of information, include signed member Consent to Release of Information.
Fax: (805) 681-3070 **OR** secure email: https:gateway.cencalhealth.org/form/bh

☐ **Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via CenCal Health's network of providers when their needs are outside the PCP scope of practice. CenCal Health can coordinate member care with the network providers.

☐ **Referral for Case Management:** Assist members with care coordination services between primary care, medical specialists, and external specialists. Provide ongoing support and management of their medical conditions. Case Management Form

REQUEST REASON (check all that apply):

☐ **Eating Disorder Diagnosis (please specify):**

Date of Diagnosis: Medical Diagnosis:

Medications (list below or send medication list with this form):

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Opioid Drug Utilization Review (DUR) Activities

- Retrospective DUR Provider Outreaches:
  - Direct outreach based on pharmacy claims data.
  - Focus on opioid utilization:
    - Concomitant use with benzodiazepines or antipsychotics.
    - High morphine milligram equivalent (MME) values.
    - Members with high MME and no naloxone utilization.

- DUR Education Articles:
  - Available on the CenCal Health pharmacy webpage.

  https://www.cencalhealth.org/providers/pharmacy/drug-utilization-review/

- CenCal Health Pharmacy Pain Management Webpage
  - Provides resources to help providers weigh risks and benefits of opioid treatment.

  https://www.cencalhealth.org/providers/pharmacy/pain-management-resources/

- Medi-Cal Rx Pharmacy Benefit
  - Providers should refer to Medi-Cal Rx Contract Drug Lists for covered medications.

  https://www.medi-calrx.dhcs.ca.gov/home/cdl/

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Contact Us: Behavioral Health Dept.

Behavioral Heath Call Center Member line
1-877-814-1861

Behavioral Heath Call Center Provider Line
(805) 562-1600

BH Department Fax Line
(805) 682-5117

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

CenCal Health Pediatric Case Management
(805) 562-1082

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Additional References

Refer to the CenCal Health Provider Manual (Section E6 & E7):
cencalhealth.org/providers/forms-manuals-policies/provider-manual/

- List of approved screening, assessment tools
- Documentation Requirements
- Approved CPT and HCPCS Codes

Cultural & Linguistic Interpreter Service Resources
https://www.cencalhealth.org/providers/cultural-linguistic-resources/

- Member Language Point Chart
- Phone & Video Remote Interpreting Services
- Alternative Format Selections (AFS) Resources

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Website Resources

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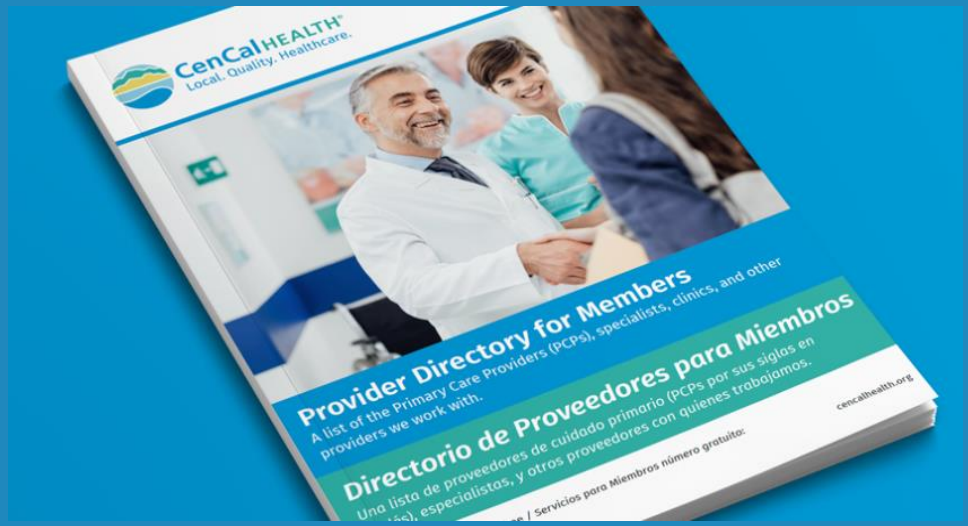
Contracted Provider List Directory

Provider Directory allows members to search for In-Network physicians, hospitals, clinics, Behavioral & Mental Health and CalAIM contracted providers with CenCal Health.



Important Tips:

- Providers need to verify, and attest to the accuracy of their information every 6 months
- Please utilize our Downloadable Roster for changes within your group such as:
  - Change "Mail-To" and "Pay-To" addresses
  - Adding additional rendering physicians
  - Add business owners, and officers
  - Change to office hours
  - Change to languages capabilities provided at your office

Provider Relations Department (805) 562-1676 or email psrgroup@cencalhealth.org
cencalhealth.org/members/provider-directory-for-members/
cencalhealth.org/providers/provider-profile-and-practice-changes

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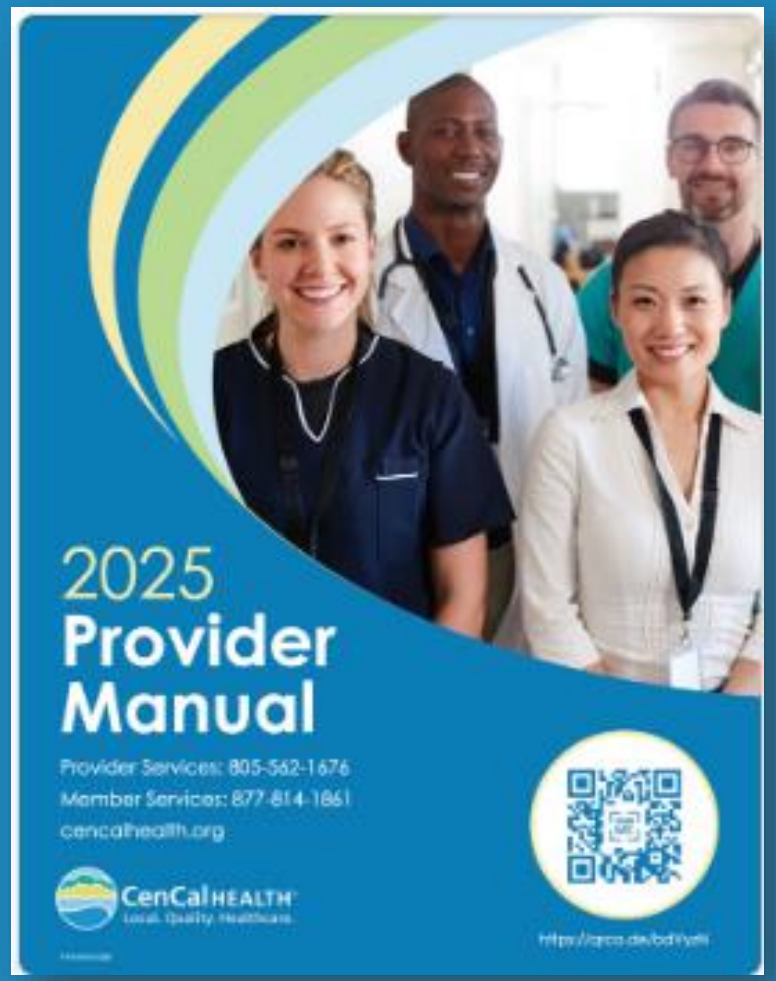
CenCal Health Provider Manual

CenCal Health Provider Manual is intended as a tool that describes operational policies and procedures and as a reference guide for CenCal Health's providers and their staff.

It contains basic information on:

- how to work with CenCal Health through provider enrollment
- provider responsibilities
- claims and billing
- Eligibility
- authorization guidelines.

Medi-Cal Manual link:
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications



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providers/forms-manuals-policies/provider-manual

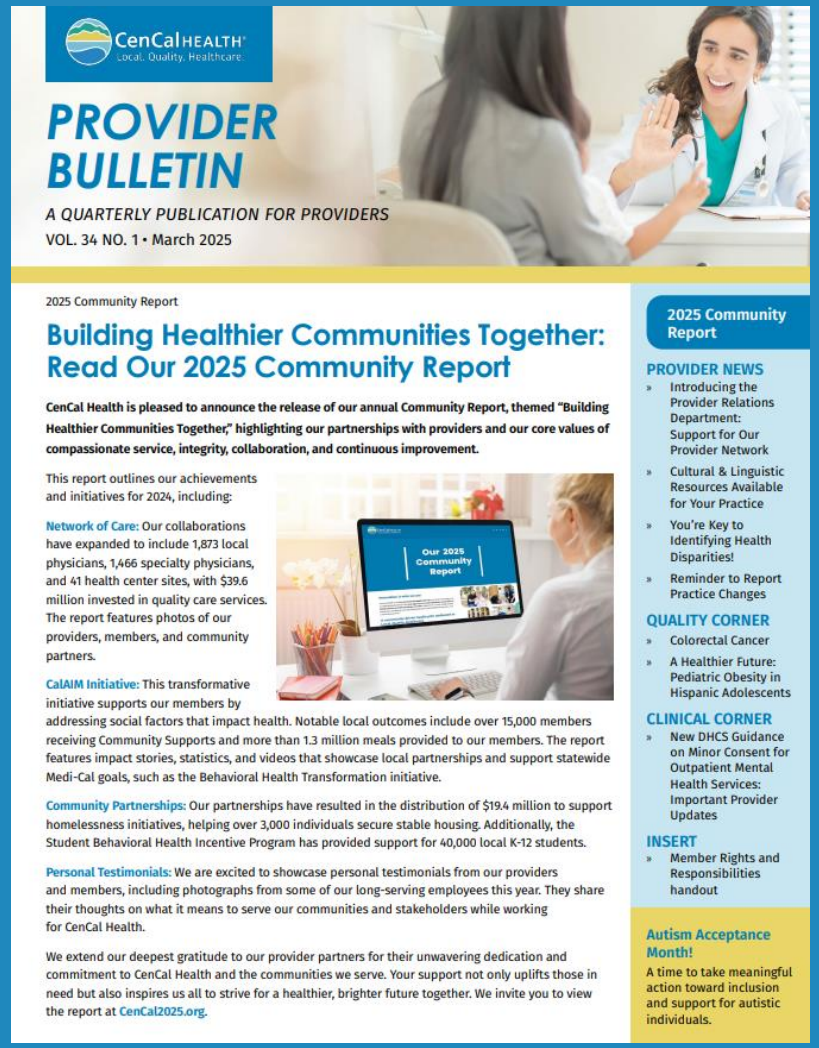
We value communication

CenCal Health shares provider news to keep contracted providers, contractors, and subcontractors informed of Medi-Cal updates, CenCal Health campaigns, resources on regulatory requirements, and more.

Sent via mail to contracted providers quarterly (March, June, September, December) and monthly via email.

Sign up today to receive electronic notifications!

Provider Relations Representatives also perform outreach calls, emails and visits.



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PROVIDER BULLETIN

A QUARTERLY PUBLICATION FOR PROVIDERS

VOL. 34 NO. 1 • March 2025

2025 Community Report

Building Healthier Communities Together: Read Our 2025 Community Report

CenCal Health is pleased to announce the release of our annual Community Report, themed "Building Healthier Communities Together," highlighting our partnerships with providers and our core values of compassionate service, integrity, collaboration, and continuous improvement.

This report outlines our achievements and initiatives for 2024, including:

Network of Care: Our collaborations have expanded to include 1,873 local physicians, 1,466 specialty physicians, and 41 health center sites, with $39.6 million invested in quality care services. The report features photos of our providers, members, and community partners.

CalAIM Initiative: This transformative initiative supports our members by addressing social factors that impact health. Notable local outcomes include over 15,000 members receiving Community Supports and more than 1.3 million meals provided to our members. The report features impact stories, statistics, and videos that showcase local partnerships and support statewide Medi-Cal goals, such as the Behavioral Health Transformation initiative.

Community Partnerships: Our partnerships have resulted in the distribution of $19.4 million to support homelessness initiatives, helping over 3,000 individuals secure stable housing. Additionally, the Student Behavioral Health Incentive Program has provided support for 40,000 local K-12 students.

Personal Testimonials: We are excited to showcase personal testimonials from our providers and members, including photographs from some of our long-serving employees this year. They share their thoughts on what it means to serve our communities and stakeholders while working for CenCal Health.

We extend our deepest gratitude to our provider partners for their unwavering dedication and commitment to CenCal Health and the communities we serve. Your support not only uplifts those in need but also inspires us all to strive for a healthier, brighter future together. We invite you to view the report at CenCal2025.org.

2025 Community Report

PROVIDER NEWS
- Introducing the Provider Relations Department: Support for Our Provider Network
- Cultural & Linguistic Resources Available for Your Practice
- You're Key to Identifying Health Disparities!
- Reminder to Report Practice Changes

QUALITY CORNER
- Colorectal Cancer
- A Healthier Future: Pediatric Obesity in Hispanic Adolescents

CLINICAL CORNER
- New DHCS Guidance on Minor Consent for Outpatient Mental Health Services: Important Provider Updates

INSERT
- Member Rights and Responsibilities handout

Autism Acceptance Month!

A time to take meaningful action toward inclusion and support for autistic individuals.

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cencalhealth.org/providers/provider-bulletin-newsletter

Provider Grievance Process

Voice your concerns in a formal manner and receive a response on your outcomes

Grievance Types include:

- Member Billing Issues
- Authorizations
- Medical Request Form (MRF)
- Claims Dispute
- Vendor Issues

Providers can also speak to our Member Services Department on behalf of a Member call
1(877) 814 - 1861

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https://www.cencalhealth.org/providers/file-grievance/

Member Grievance Process

A CenCal Health member, has many rights and responsibilities and both are very important to know and understand.

How Members can File a Complaint/Appeal:

- Call 1 – 877 – 814 – 1861

  Or, if a member cannot hear or speak well, they can call

  California Relay at 711 or TTY: 1-833-556-2560

- In Writing via Downloadable Member Grievance Form (English/Spanish Available)

  CenCal Health

  Attention: Grievance and Appeals Coordinator

  4050 Calle Real, Santa Barbara, CA 93110

- On-Line Grievance Form

  https://www.cencalhealth.org/members/file-complaint/

Referrals & Authorizations

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Authorization Types

All authorizations are submitted under the Provider Group level, not the individual practitioner.

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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".

Referral Authorization Form (RAF)

RAFs allow Primary Care Physician (PCP) Group to refer their assigned members to a In-Network Specialist and/or tertiary facility

Specialists are advised to make sure the RAF is approved prior to rendering services

Payment may be delayed or denied if the provider renders services without an approved RAF and/or if the member is not eligible on date of service

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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.

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cencalhealth.org/providers/authorizations/referrals/

Referral Authorization (RAF) Portal Demo

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RAF Video Tutorial
https://vimeo.com/1014447849/5e70596105?ts=0&share=copy

Paper Authorization Forms

New Utilization Management Authorization Download Form can be used for providers that don't have access to our portal, and when a contracted PCP wants to refer to an out of network provider

Form Requirements:

- Member Name, ID#, DOB, Age
- Diagnosis Code & ICD-10 Code
- RAF or TAR
  - Referring Provider Group NPI
  - Provider Rendering Service MD NPI# & Group NPI#
  - Office Contact
- 18-1 or 20-1
  - Indicate Inpatient Facilty, Outpatient Facility or SNF
  - Effective Dates & Through Date
  - Facility NPI
  - Office Contact
- List all Procedures Requested with CPT or HCPCS, Qty, Units

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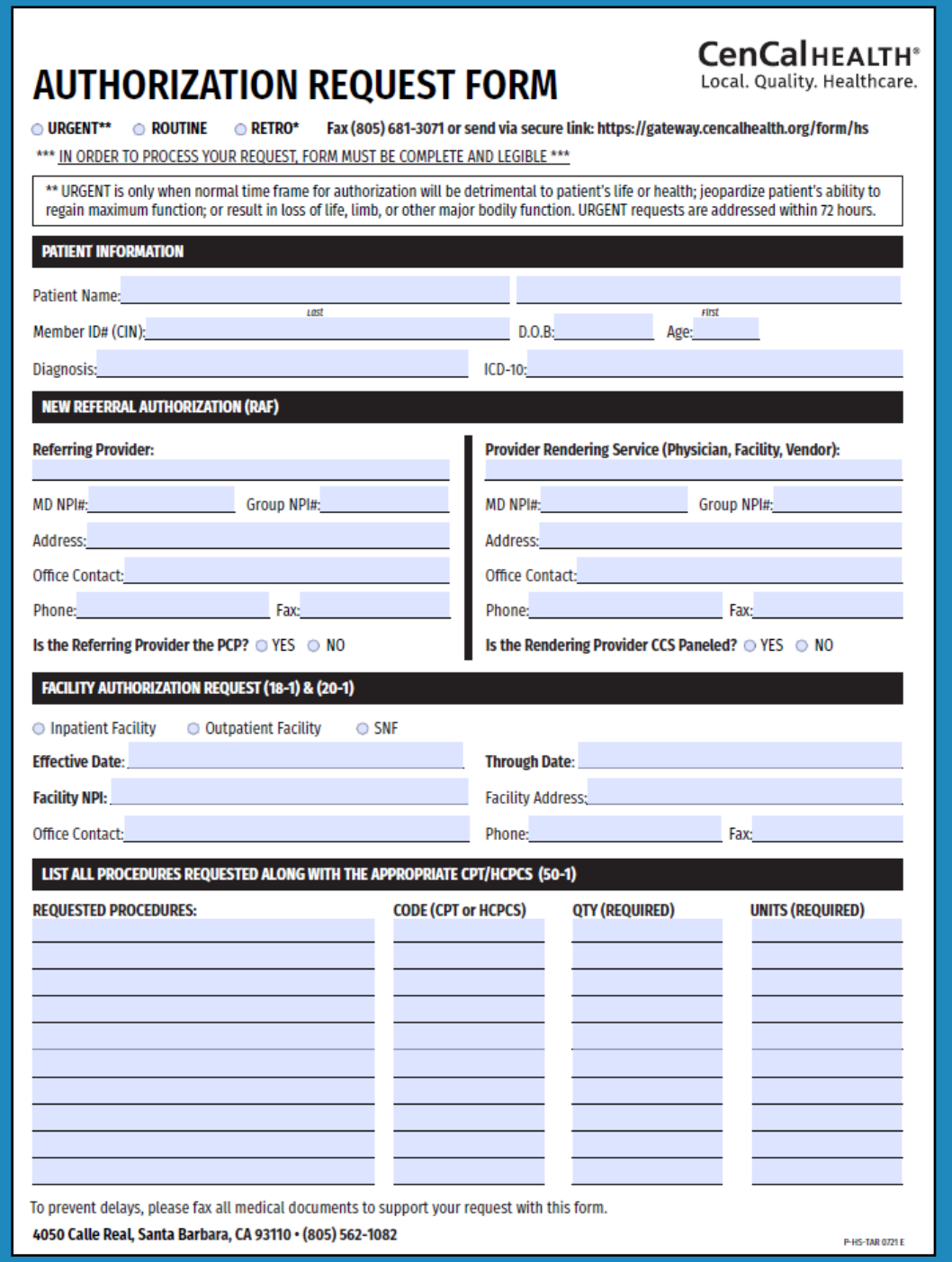

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AUTHORIZATION REQUEST FORM

○ URGENT** ○ ROUTINE ○ RETRO* Fax (805) 681-3071 or send via secure link: https://gateway.cencalhealth.org/form/hs

*** IN ORDER TO PROCESS YOUR REQUEST, FORM MUST BE COMPLETE AND LEGIBLE ***

** URGENT is only when normal time frame for authorization will be detrimental to patient's life or health; jeopardize patient's ability to regain maximum function; or result in loss of life, limb, or other major bodily function. URGENT requests are addressed within 72 hours.

PATIENT INFORMATION

Patient Name: _____ (Last) _____ (First)

Member ID# (CIN): _____ D.O.B: _____ Age: _____

Diagnosis: _____ ICD-10: _____

NEW REFERRAL AUTHORIZATION (RAF)

Referring Provider:

MD NPI#: _____ Group NPI#: _____

Address: _____

Office Contact: _____

Phone: _____ Fax: _____

Is the Referring Provider the PCP? ○ YES ○ NO

Provider Rendering Service (Physician, Facility, Vendor):

MD NPI#: _____ Group NPI#: _____

Address: _____

Office Contact: _____

Phone: _____ Fax: _____

Is the Rendering Provider CCS Paneled? ○ YES ○ NO

FACILITY AUTHORIZATION REQUEST (18-1) & (20-1)

○ Inpatient Facility ○ Outpatient Facility ○ SNF

Effective Date: _____ **Through Date:** _____

Facility NPI: _____ Facility Address: _____

Office Contact: _____ Phone: _____ Fax: _____

LIST ALL PROCEDURES REQUESTED ALONG WITH THE APPROPRIATE CPT/HCPCS (50-1)

REQUESTED PROCEDURES:	CODE (CPT or HCPCS)	QTY (REQUIRED)	UNITS (REQUIRED)

To prevent delays, please fax all medical documents to support your request with this form.

4050 Calle Real, Santa Barbara, CA 93110 • (805) 562-1082

P-HS-TAR 0721 E

Submit Paper Authorization Forms & Medical Justification Notes

Fax Adult (21yrs and older) documentation
(805) 681-3071
Fax Pediatric (0-20yrs) documentation
(805) 692-5140
Secure Link https://gateway.cencalhealth.org/form/hs

Attach within Provider Portal

Authorization 'A' number (#) will be generated and faxed to the point of contact listed on the form once a determination is made

Form available:

- https://www.cencalhealth.org/providers/authorizations/
- Provider Portal Authorization Section

Faxing & Secure File Drop Requirements:

- Add a cover page
- Point of Contact Phone/Email Address
- Contact Name
- Department
- Number of pages you are faxing over
- Reference the Auth# on the top of every document

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Authorization Review Timeframe

Routine authorizations will have determination within 5 working days, but up to 14 calendar days if additional clinical information is requested.

Expedited/Urgent authorizations are processed no later than 72hours from the receipt of referral request.

- The request can be downgraded upon initial review if determined non urgent.

Post Service Requests will have a 30 day review period.

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Radiology Benefit

CARE *to* CARE

MULTI-SPECIALTY MANAGEMENT

This program applies to the following outpatient services:

- Positron Emission Tomography (PET)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Computed Tomography (CT)
- Computed Tomography Angiography (CTA)
- Nuclear cardiology studies

Exceptions:

- Imaging studies performed in conjunction with emergency room services
- Inpatient Hospitalization
- Urgent Care Centers
- Intra-Operative procedures are excluded from the high-tech imaging consultation requirement
- Imaging study consultations for members who have other health care coverage are excluded

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Clinical Information Required

- Imaging study(ies) being requested, with current CPT codes
- Presumptive diagnosis or "rule out" with current ICD-10 codes
- Patient's signs and symptoms, listed in some detail, with severity and duration
- Any treatments that have been tried, including dosage and duration for drugs, and dates for other therapies
- Any other information that the provider believes will help in evaluating the request; this may include physical exam findings, prior medical history, etc.

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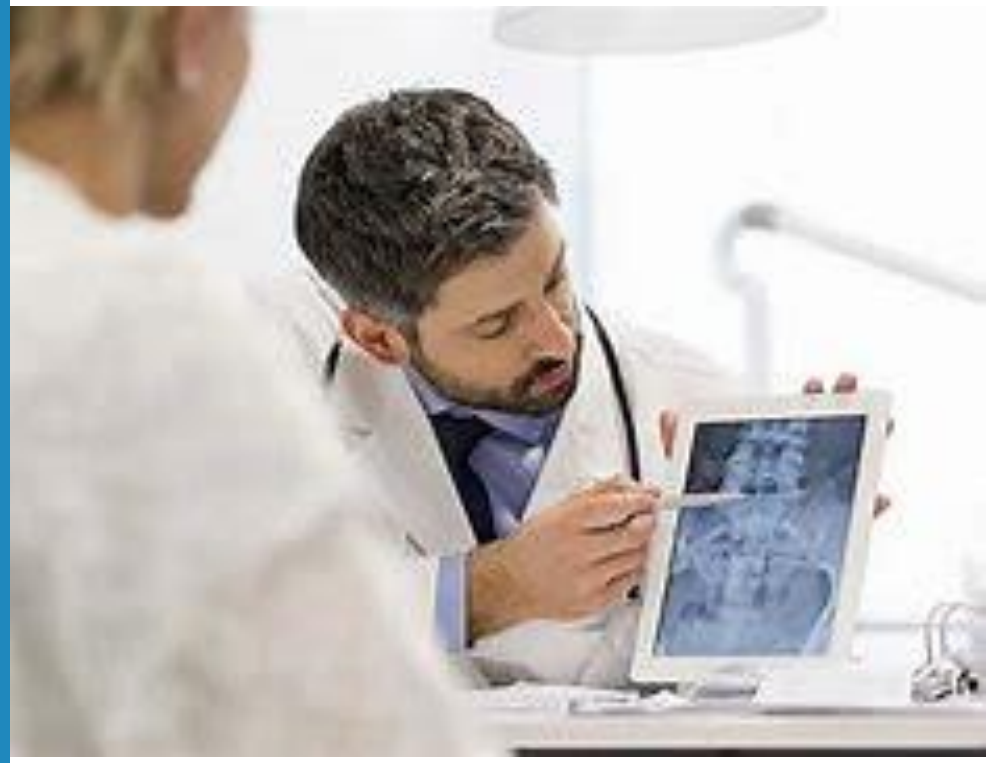

cencal.careportal.com/

Contact Care to Care

Phone 1 (888) 318-0276,
Mon. – Fri 5am – 5pm
(Pacific Standard Time)

Fax 1 (888) 717-9660

Web: cencal.careportal.com

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Grievance & Appeals

Authorization & RBM High Tech Imaging Requests

- Submitted within 60 calendar days from the decision date
- Need copy of original TAR and denial notification
- Letter stating why denial should be overturned
- New supporting documentation
- For RBM pre-service authorizations call Member Service 1 (877) 814-1861
  - Pre-Service appeals go to the G&A Group in Member Services for review
- Post service requests to Medical Management (805) 562-1082

CenCal Health
Medical Management Department
4050 Calle Real
Santa Barbara, CA 93117

Medical Request Form (MRF)

- Submitted within 60 calendar days from decision date
- Copy of original or modified MRF
- Letter stating why denial should be overturned

CenCal Health
Pharmacy Services Department
4050 Calle Real
Santa Barbara, CA 93117

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Claims & Billing

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Claims & Billing

Once a provider receives confirmation on their effective date with CenCal Health, payment is payable at the contracted rate.

"Clean" claims will be reimbursed within 30 working days of receipt. Clean claims are claims that include all the necessary, accurate and valid data for adjudication.

CenCal Health offers (3) three easy and convenient ways to bill:

1. CenCal Health Provider Portal
2. Electronic via EDI Team edi@cencalhealth.org
3. Paper Mailing
   CenCal Health
   PO Box 948
   Goleta, CA 93116-0948

Submitting a paper claim on the CMS-1500 Form

Arrows on the claim form highlight the following areas:

1. Member Info
2. Diagnosis codes (at least one code required)
3. Service lines, including:
    - Date of service (DOS)
    - Place of Service (POS)
    - Procedure code
    - Modifiers
    - Billed Amount
    - Number of Units
4. Billing Provider Information
    - Provider Group NPI#
    - Service Address
    - Billing Address)

For more claim information and submission guidelines:
https://www.cencalhealth.org/providers/claims/

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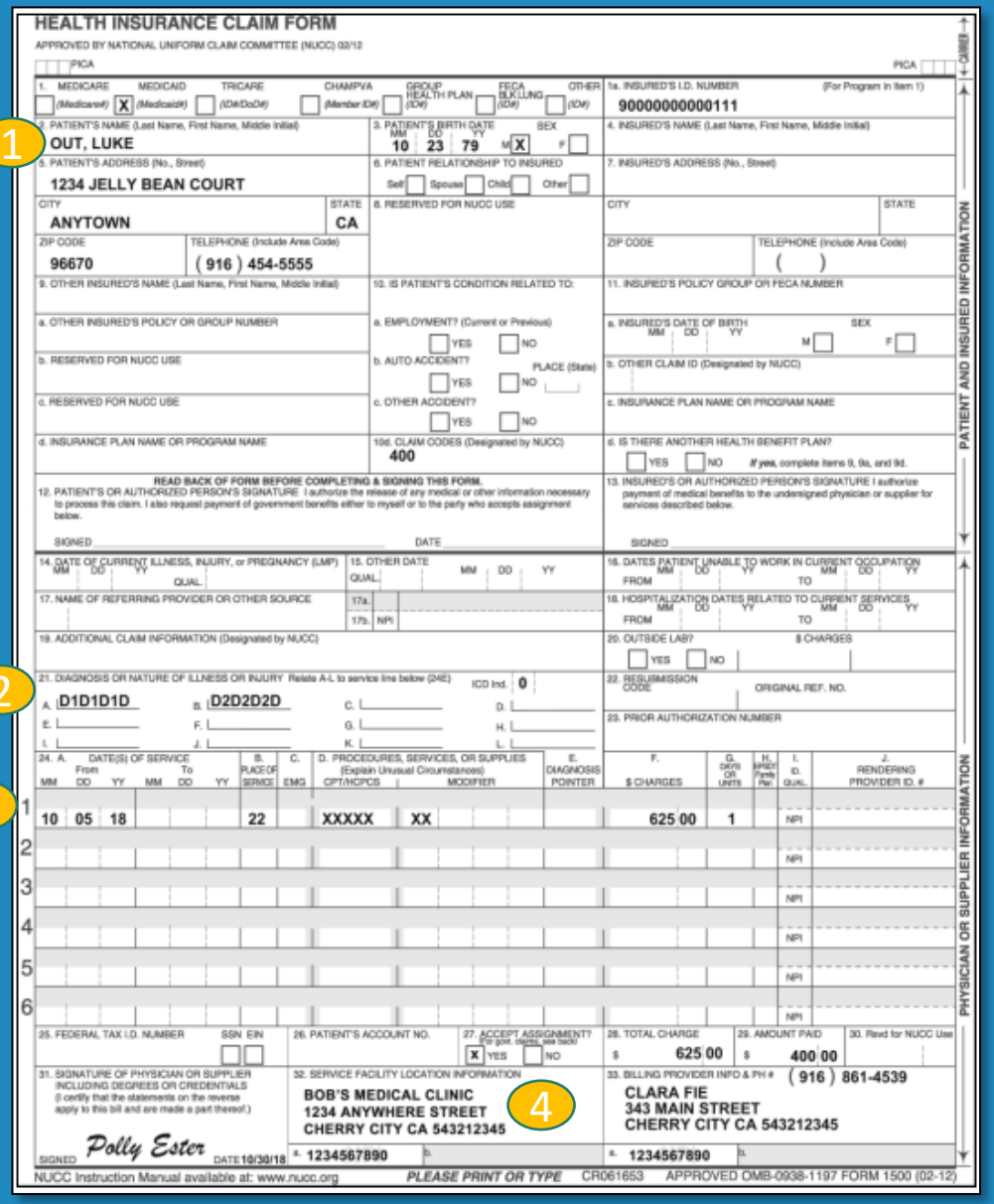
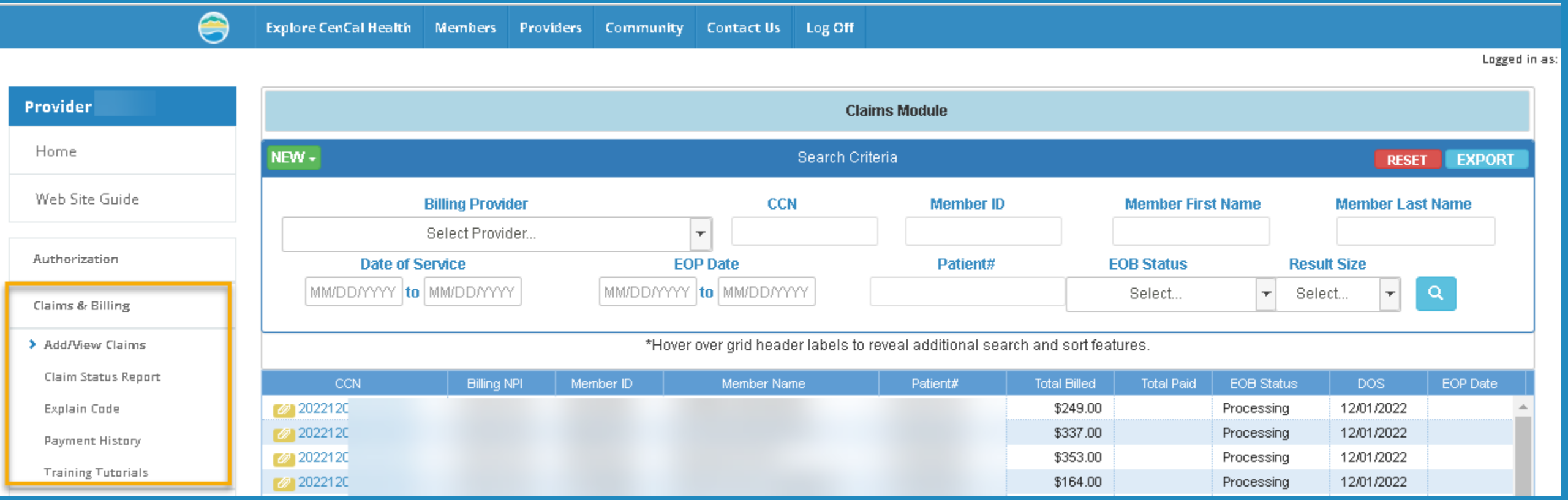


Provider Portal Claims Module



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Claims Main Dashboard Video Tutorial
https://vimeo.com/1001281895/55f79b00ff?share=copy

CMS-1500 Claims & Billing Portal Demo

Claims CMS-1500 Video Tutorial
https://vimeo.com/1001282395/f0a65374dd?share=copy

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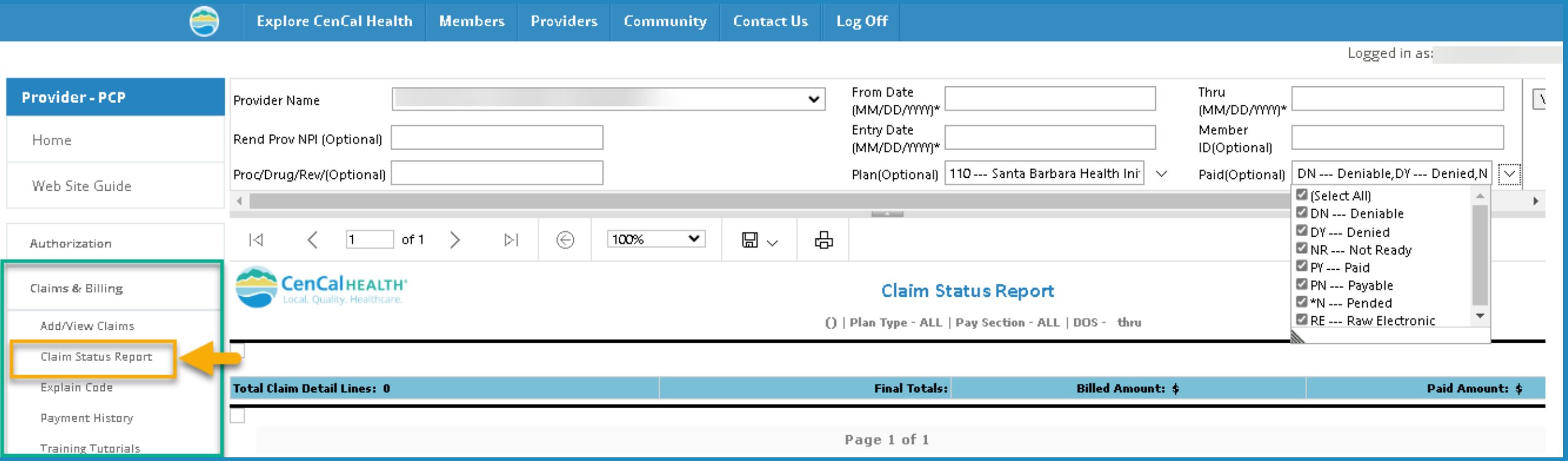
Claims Status Report



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Claims Status Report Video Tutorial
https://vimeo.com/1000475826/b7c06e5b66?share=copy

Timely Filing Guidelines

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Original Claim Reduction in Reimbursement Policy

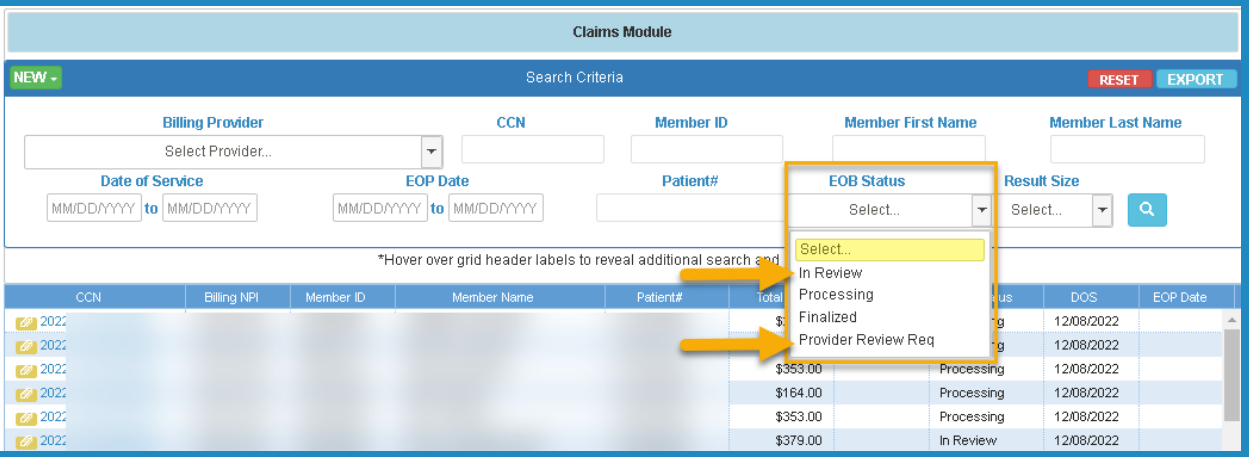
- Payable claims received **within 6 months** from the date of service will receive 100% of the CenCal/Medi-Cal allowed amount, unless otherwise noted per special contract or OTA.

- Payable claims received within the **7th to the 9th month will be reduced by 25%** and receive 75% of the CenCal/Medi-Cal allowed amount, unless otherwise noted per special contract or OTA. **(1B explain code)**

- Payable claims received within the **10th to the 12th month will be reduced by 50%.** Payment will be 50% of the CenCal/Medi-Cal allowed amount, unless otherwise noted per special contract or OTA. **(1C explain code)**

Original Claims received beyond 1 year from date of service will be denied. Delay reason codes and supporting documentation per Medi-Cal guidelines can be submitted for review.

Claim Correction Requirements



- When a claim's EOB status is "In review, or processing; corrections can be made on the portal. Simply click the blue hyperlink, make the corrections and save. Changes can be seen immediately.

- Claims that have an EOP status of "Finalized" are no longer eligible to be corrected on the portal. These claims are finalized and A new claim submission will need to be submitted for processing.

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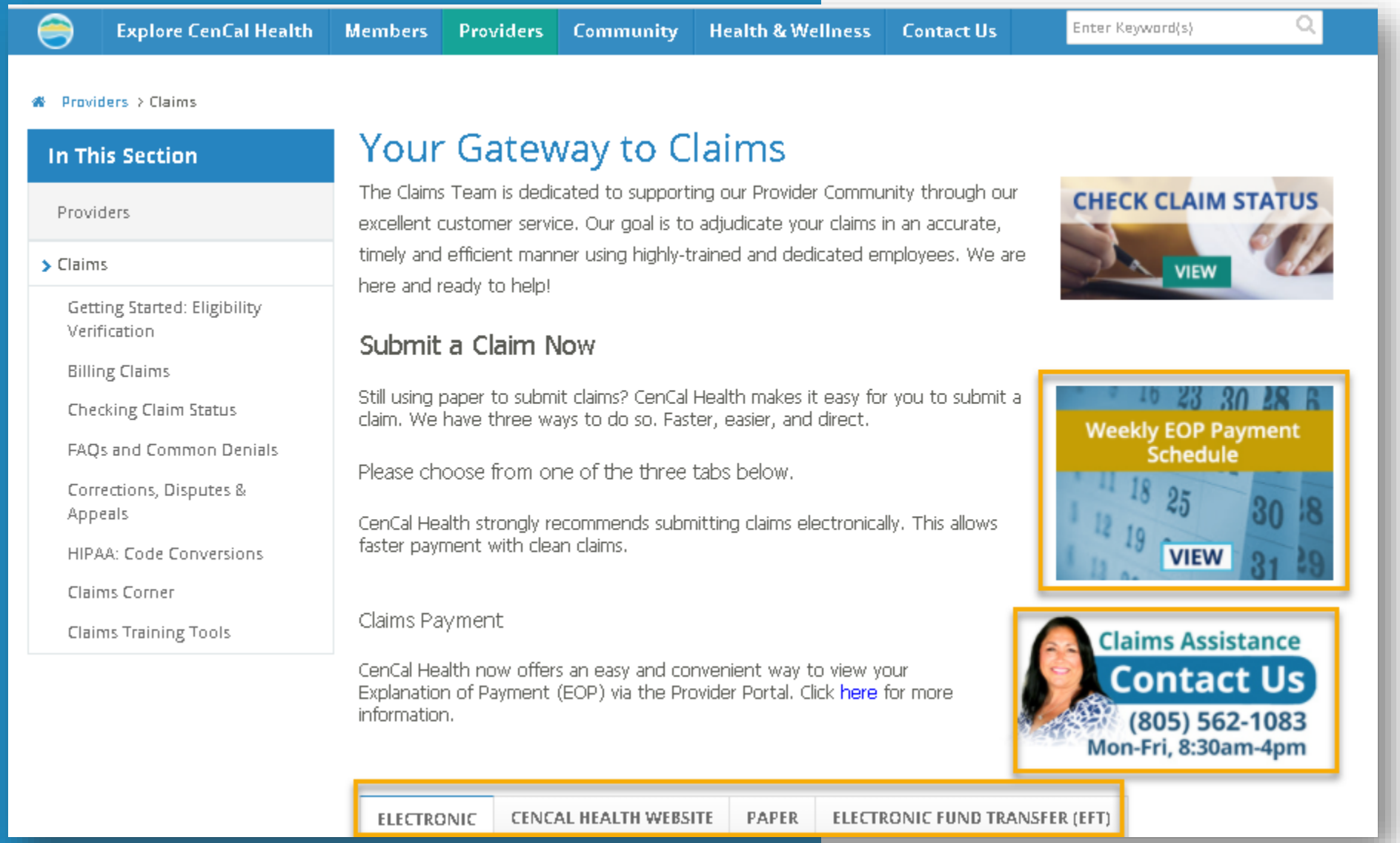
Claims & Billing

www.cencalhealth.org/providers/claims/



Coding for Social Determinant of Health (SDOH)

Why is it important?

Helps identify health disparities, and their root causes, that are negatively impacting our members' health.

Categories

1. Education/literacy
2. Employment
3. Occupational exposure to risk factors
4. Housing and economic circumstances
5. Social environment
6. Upbringing
7. Primary support group, including family circumstances
8. Psychosocial circumstances

Code	Description
Z55.0	Illiteracy and low-level literacy
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)
Z59.3	Problems related to living in residential institution
Z59.41	*Food insecurity*
Z59.48	*Other specified lack of adequate food*
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*
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
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
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

For more resources and a full list of codes go to: www.cencalhealth.org/providers/social-determinants-of-health/

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