

2027
Provider Manual

Provider Services: 805-562-1676
Member Services: 877-814-1861
cencalhealth.org

CenCal HEALTH®
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CenCal CareConnect™

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Section A: Introduction

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

A1: Welcome to CenCal Health

CenCal Health is a County Organized Health System (COHS) model for California's Medi-Cal managed care program. CenCal Health provides Medi-Cal health insurance coverage, including a Medi-Cal/Medicare plan, to Santa Barbara County and San Luis Obispo County residents who meet Medi-Cal and/or Medicare qualifications. CenCal Health is governed by a Board of Directors with members appointed by the San Luis Obispo County and Santa Barbara County Boards of Supervisors, and includes health plan members, network providers, business leaders, and local government representatives. We work with a vast network of dedicated and compassionate physicians, physician assistants, nurse practitioners, pharmacists, therapists, and other healthcare professionals who care for our members. CenCal Health provides health insurance coverage for 1 in 3 people in Santa Barbara County, and 1 in 4 in San Luis Obispo County. We provide services to children, low-income families, seniors, and persons with disabilities. CenCal Health's insurance programs are built on a foundation of comprehensive and coordinated patient-centered care through the collaboration of physicians, care managers, and other healthcare providers. Our *mission is 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.*

CenCal Health recognizes that the strength of our programs depends upon strong collaboration and communication with our provider partners and their staff. We look forward to working with each provider and their staff to provide our members with high-quality, cost-effective care.

A2: Intent of this Provider Manual

The Provider Manual, or Manual, describes operational policies and procedures for CenCal Health that apply to the provider network. Topics covered in this Provider Manual include, but are not limited to: member eligibility, authorizations, referrals, covered services, services covered by other agencies, care management, cultural and linguistic services, utilization management, quality assurance and improvement, health assessment and screening, member and provider grievances, billing, coordination of benefits, reporting, credentialing, and dispute resolution for providers and their staff.

Notice: CenCal Health may periodically modify or amend existing policies or implement new policies and procedures. The Manual is reviewed and updated periodically to address such changes. Reviews by the Quality Improvement and Health Equity Committee (QIHEC) are conducted on an annual and as-needed basis. In the event of a conflict or inconsistency between this Manual and other documents or laws, the following apply in the order of primary precedence: first, federal and state statutes,

regulations, and regulatory guidance; second, CenCal Health's provider contract; third, the Manual; and fourth, CenCal Health policies.

CenCal Health drafted the Provider Manual as a tool to assist providers with understanding CenCal Health policies and procedures applicable to the oversight and delivery of services to CenCal Health members.

We encourage providers to become familiar with the contents of the Provider Manual and to refer to it frequently.

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

Reference Links:

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

CMS Medicare Manual
www.cms.gov/medicare/regulations-guidance/manuals

A3: Overview of CenCal Health's Lines of Business

The following section briefly describes CenCal Health's two lines of business. Our lines of business include Medi-Cal and a Dual Special Needs Plan, or D-SNP, called CenCal CareConnect (HMO D-SNP).

Medi-Cal

CenCal Health is a publicly funded Medi-Cal Managed Care Health Plan. When a resident of either Santa Barbara or San Luis Obispo County is identified as eligible for full-scope Medi-Cal, they are automatically enrolled into CenCal Health. New members receive a Welcome Packet that provides a Member Handbook, also known as an Evidence of Coverage (EOC), that explains the benefits available to members along with a listing of doctors, specialty providers, hospitals, behavioral health and mental health providers, Enhanced Care Management (ECM) and Community Supports (CS), and pharmacies available to members of CenCal Health.

The Medi-Cal program 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 covers:

- Infants and children
- Families with children
- Foster care children
- Pregnant women
- Childless adults
- Seniors

- Persons with disabilities

Individuals and families apply for Medi-Cal through their County Department of Social Services or through Covered California. Applications may be completed in person, online, through the mail, or over the phone. Elderly and disabled individuals who receive Supplemental Security Income (SSI) automatically receive Medi-Cal along with their SSI benefit.

Eligibility for Medi-Cal is month-to-month. Medi-Cal recipients must re-certify their eligibility periodically. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Please note that a member's eligibility must be verified before delivery of services, and the CenCal Health identification card alone is not a guarantee of eligibility. Please refer to Section G: Eligibility Verification and Enrollment of the Provider Manual for further eligibility information, or consult CenCal Health's website for additional information about eligibility.

Not all Medi-Cal beneficiaries are CenCal Health members. Those who are not CenCal Health members are eligible under the Medi-Cal Fee-For-Service system (FFS Medi-Cal). Providers who care for these beneficiaries bill Medi-Cal directly and are reimbursed for covered services by Affiliated Computer Services, the state Medi-Cal fiscal intermediary.

CenCal CareConnect (HMO D-SNP)

CenCal CareConnect is CenCal Health's Dual Eligible Special Needs Plan (D-SNP), a type of Medicare Advantage plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. Patients who are dually eligible for Medicare (Parts A, B, and D) and full benefit Medi-Cal and who reside in either San Luis Obispo County or Santa Barbara County may enroll in CenCal CareConnect. These members are often referred to as "Medi-Medi's" or "duals".

CenCal CareConnect offers important advantages for members and their providers:

- CenCal CareConnect offers enhanced care coordination and streamlined health care delivery by combining Medicare, Medicare prescription drug, and Medi-Cal benefits into a single plan. CenCal Health's goal is to make it easier for our dual-eligible members to understand and access health care services. Through enhanced care coordination and integrated utilization management processes, we also support our providers' ability to furnish comprehensive patient-centered care for their patients.
- CenCal CareConnect provides additional benefits beyond traditional Medicare and Medi-Cal services, including vision and hearing services as well as an over-the-counter flex card benefit.

Reference Link:

CenCal Health Provider Medi-Cal Eligibility Resources
www.cencalhealth.org/providers/eligibility/

A4: Glossary of Terms

The glossary of terms contains definitions of commonly used terms at CenCal Health. The glossary was written to help give people the words and meanings for each acronym.

Reference Link:
Explore CenCal Health's Glossary of Terms
www.cencalhealth.org/explore-cencal-health/glossary-of-terms/

A5: Provider Communication

CenCal Health is dedicated to keeping our contracted providers, contractors, and subcontractors well-informed about critical Medi-Cal and Centers for Medicare & Medicaid Services (CMS) regulations, guidelines, updates, and initiatives. We share comprehensive provider news that includes information on regulatory requirements, CenCal Health campaigns, new programs, benefit changes, claims processing, clinical updates, pharmacy developments, CenCal CareConnect, and behavioral and mental health resources, as well as educational opportunities.

Our Provider Bulletins and E-Newsletters (www.cencalhealth.org/providers/provider-bulletin-newsletter/) are key communication tools for our provider partners. Our Printed Bulletin is published quarterly in March, June, September, and December. This newsletter is mailed directly to contracted provider groups via USPS mail, ensuring timely access to vital information.

In addition to the quarterly bulletins, we produce **monthly digital Provider Pulse E-Newsletters**, which are emailed to contracted provider groups. Individual provider staff members can easily subscribe to receive this electronic newsletter by completing CenCal Health's online registration form.

Both our monthly and quarterly newsletters provide valuable insights for front office, back office, and medical personnel, helping them stay updated on essential topics that impact their practices.

While non-contracted providers do not receive the printed publications, they can sign up to receive the electronic newsletter via email.

For easy access to all our publications, please visit our online resource at www.cencalhealth.org/providers/provider-bulletin-newsletter/.

In addition, CenCal Health periodically sends Provider News Flash notifications containing urgent and/or regulatory communications to our provider network. These alerts may include vital information from the Department of Health Care Services (DHCS), the California Department of Managed Health Care (DMHC), and the Centers for Medicare and Medicaid Services (CMS) such as All Plan Letters (APLs) or Health Plan Management System (HPMS) memos, which inform CenCal Health of new guidelines

and standards for Medi-Cal and Medicare services. CenCal Health communicates any required changes to our provider network.

Please reference the Provider All Plan Letters (APL) section of our website for Relevant Provider Takeaways.

Reference Links:
Provider Bulletin News
www.cencalhealth.org/providers/provider-bulletin-newsletter/
Provider Bulletin Electronic Registration Form
https://cencalhealth.us4.list-manage.com/subscribe?u=7dd3f5945f5855d9526b91b0f&id=ca9deeafab

CenCal Health All Plan Letter
www.cencalhealth.org/providers/forms-manuals-policies/all-plan-letters/

A6: CenCal Health Mission, Vision, and Values

Our Mission: To improve the health and well-being of the communities we serve by providing access to high-quality health services, along with education and outreach, for our members.

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

Our Values:

- **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.

Misson:
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 membership.

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

Values
- Compassionate Service
- Collaboration
- Integrity
- Improvement



A7: About CenCal Health

CenCal Health is the local Medi-Cal managed care plan dedicated to serving Santa Barbara and San Luis Obispo counties. We collaborate with over 1,800 local physicians, hospitals, clinics, and other providers to deliver essential healthcare services to our members. Currently, our plan serves more than 225,000 members, representing one in three residents of Santa Barbara County and one in four in San Luis Obispo County.

We are a public entity governed by a 13-member Board of Directors, appointed by the Boards of Supervisors from both counties. This diverse board, composed of member representatives, local government representatives, physicians, hospital representatives, healthcare providers, and business leaders, ensures that our operations reflect the priorities of the communities we serve. While we function as a public entity, we prioritize operational efficiency akin to a business, maintaining a responsible stewardship of taxpayer dollars.

Founded over 40 years ago as the Santa Barbara Health Initiative, CenCal Health originated as a pilot program developed by visionary Dr. Lawrence Hart, alongside the local medical community and the Board of Supervisors. Utilizing the County Organized Health System (COHS) model, we are the sole health plan serving full-scope Medi-Cal beneficiaries in our regions. Notably, CenCal Health is recognized as the first Medicaid managed care initiative of its kind in the nation, playing a vital role in promoting community health and providing life-saving care to some of our most vulnerable residents during their times of greatest need.

Although CenCal Health has grown and evolved over the years, we remain committed to our core mission, which is carried out with the invaluable support of our healthcare

partners: 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.

To learn more, visit: www.cencalhealth.org/explore-cencalhealth

Section B: Provider Resources

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

B1: CenCal Health Contact Information

Please note that any emails sent to the contacts below should be encrypted should they contain any PHI.

Department	Contact Information
Member Services	Phone: 877-814-1861
Provider Relations	Phone: 805-562-1676 Toll-free: 800-421-2560, ext. 1676 Email: providerservices@cencalhealth.org or Email: psrgroup@cencalhealth.org
Claims Operations	Phone: 805-562-1083 Toll-free: 800-421-2560, ext. 1083 Email: cencalclaims@cencalhealth.org
Medical Management	Phone: 805-562-1082 Toll-free: 800-421-2560, ext. 1082 **Care to Care (Radiology Benefit Manager)** Phone: 877-931-2227 **Utilization Management** Phone: 805-562-1082, Option 1 **Case Management** Phone: 805-562-1082, Option 2 **Adult Disease Management** Phone: 805-562-1082, Option 4 **Pediatric Case Management & CCS** Phone: 805-364-4950 **Behavioral Health** Phone: 805-562-1600 **CalAIM Community Supports (CS) Services** Phone: 805-562-1698, Option 1 Email: communitysupports@cencalhealth.org

	Enhanced Care Management (ECM) & Community Supports (CS) Services Phone: 805-562-1698, Option 2 Email: Enhanced_Care_Management@cencalhealth.org
CenCal CareConnect (HMO D-SNP)	Phone: 805-562-1050 Email: CareConnectCareManagement@cencalhealth.org
CenCal CareConnect Enrollment	Toll-free: 877-227-3051 (TTY: CA Relay at 711)
Population Health	Phone: 805-617-1997 Email: populationhealth@cencalhealth.org
Pharmacy Services	Phone: 805-562-1080 Toll-free: 800-421-2560, ext. 1080
Video & Telephonic Interpreter Services	**Phone Interpreter Service** Phone: 800-225-5254 Operator Customer Code: 48CEN **Video Remote Interpreter Service** MERFi Web Address: cencalhp.cli-video.com MERFi Access Code: 48cencalhp Main Website: certifiedlanguages.com **Sign Language** 877-814-1861
Alternative Format Selections	Medi-Cal Health Line: 833-284-0040 Website: https://afs.dhcs.ca.gov/
Finance – Recoveries Unit	Phone: 805-562-1081 Toll-free: 800-421-2560, ext. 1081
Fraud, Waste, and Abuse Reporting	Compliance Hotline: 866-775-3944 Mail: CenCal Health Attn: Compliance Investigator 4050 Calle Real Santa Barbara, CA 93110 Email: compliance@cencalhealth.org

Reference Links:
Medi-Cal Provider Manuals are available on the Department of Health Care Services website.
www.dhcs.ca.gov/formsandpubs/publications/Pages/Medi-CalProviderManuals.aspx
CenCal Health Contact Us
www.cencalhealth.org/contact-us/

The Compliance Alert Line
https://cencalhealth.alertline.com/gcs/overview

The CenCal Health Provider Compliance website
www.cencalhealth.org/providers/suspect-fraud/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

B2: Provider Resources on CenCal Health's Website

The CenCal Health website provides information, including resources and other helpful tools, for providers and members. Resources include, but are not limited to:

- **The CenCal Health Provider Portal:** Contracted providers may use the CenCal Health Provider Portal to verify eligibility, check the status of CenCal Health claims, and submit authorizations. Providers must register with CenCal Health to utilize this secure resource.
- **Provider Manual:** The Provider Manual is a guide that provides general information relative to the provision of healthcare goods and services to CenCal Health members.
- **Provider Directory:** The Provider Directory is a list of CenCal Health contracted providers. The Provider Directory can be searched by program name, health network, provider name, specialty, or location.
- **Patient Education Materials:** CenCal Health offers a wide range of health education materials to support your patients across various topics. These resources are available in multiple threshold languages and can be easily accessed online: www.cencalhealth.org/providers/patient-education-materials/
- **Provider Communications:** This section of the website includes the monthly provider newsletter, as well as Provider Updates based on recent Operating Instruction Letters received by the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS).
- **CenCal Health Policies and Procedures:** A complete library of CenCal Health policies by program located in the "Forms, Manuals and Policies" section of the website.
- **CenCal CareConnect Comprehensive Formulary Prescription Drug Coverage:** Covered and non-covered prescriptions and proper medication use with Point of Service (POS) drug utilization review (DUR) approved by CMS.

- **CenCal CareConnect Comprehensive Formulary Prescription Drug Coverage:** Covered and non-covered prescriptions and proper medication use with Point of Service (POS) drug utilization review (DUR) approved by CMS.

Reference Links:
CenCal Health Provider Portal
www.cencalhealth.org/providers/provider-portal/

CenCal Health Provider Manual
www.cencalhealth.org/providers/forms-manuals-policies/provider-manual/

Search CenCal Health Provider Network Directory
www.cencalhealth.org/providers/search-provider-network/

CenCal Health & Wellness
www.cencalhealth.org/health-and-wellness/

CenCal Health Policies & Procedures
www.cencalhealth.org/providers/forms-manuals-policies/policies-procedures/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

B3: Provider Education Resources and Training Requirements

CenCal Health delivers education and training on a broad range of topics to its provider network. These trainings are designed to strengthen relationships between CenCal Health and its providers, as well as between providers and members, while supporting the overall goal of enhancing the quality of care and services available to Medi-Cal and dual-eligible beneficiaries.

These training events may feature guest speakers and subject matter experts and reflect the most current information available to contracted network providers, contractors, and subcontractors.

CenCal Health hosts training events throughout the year in a multitude of ways. Trainings may be offered in person, via live virtual trainings, or through e-learning platforms, which are available online at www.cencalhealth.org/providers/provider-training-resources/. Training engagements may include visual and/or audio aids and handouts. Program lengths vary depending on the content, and live virtual trainings conclude with a question-and-answer session.

New Provider Orientation (NPO): When new providers and rendering practitioners credential and contract with CenCal Health, Provider Relations staff will conduct a training to provide instructions and materials that help providers become acquainted with CenCal Health's programs and operations. These include, but are not limited to, billing processes, provider/member grievance policy, member eligibility, Cultural Competency, Seniors and Persons with Disabilities (SPD) processes, Linguistic & Interpreter Services, Diversity, Equity, and Inclusion (DEI) policies, authorizations, and a demonstration of the Provider Portal. The NPO training provides the background and education necessary to operate in full compliance with CenCal Health's Medi-Cal and CenCal CareConnect (HMO D-SNP) Program.

The NPO training is offered within 10 working days and is completed 30 working days after a provider or practitioner is placed on active status. A CenCal Health onboarding packet is made available to the provider during onboarding and includes a full review of CenCal Health policy requirements. The onboarding packet contains much of the information the provider will need to begin to provide care and services to members of CenCal Health's programs, and a New Provider Training Attestation Form is signed, stating that the provider has received such material. Provider Services staff are available by phone and email for questions and will make return visits as needed, in person or virtually.

Provider In-Service Office Visits & Training Visits: Provider Relations staff routinely visit provider offices to help maintain a mutually beneficial relationship between the provider and CenCal Health. These visits create opportunities for the provider to ask questions and for the representative to deliver current information or materials. Meetings may be scheduled at the provider's request and convenience to discuss specific issues. Additional CenCal Health staff may be included in these meetings, as appropriate.

Basic Training: This training is offered quarterly via online training webinars for the convenience of providers and covers a multitude of topics. This training is designed to expand on the initial instruction and materials provided to new providers.

Claims & Billing: This training course is for office staff who are unfamiliar with medical billing for CenCal Health. It is provided twice a year and tailored to the needs of the providers involved. Individualized assistance with claims submittal is also available through the Claims Department by a Claims Representative.

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

CenCal Health Provider Portal Training: These video training courses are available online and provide education on the various tools available to providers via the Provider Portal. This training includes a demonstration of the Provider Portal and how to use its

features, i.e., checking eligibility, submitting authorizations and referrals, and reviewing how to access various reports. It also covers the Coordination of Care portal, as well as claim submittals and accessing the electronic Explanation of Payments (EOP). This training may also be scheduled at the provider's request via an In-Service office training by the Provider Relations Representatives for convenience.

Special Topics: There are a variety of programs offered to specific audiences or specific topics that may be conducted annually or on an as-needed basis. They are usually developed to serve an identified need or to inform certain provider types of provider-specific support and resources. These may include training events specific to office managers and hospitals, or seminars that relay information on changes to CenCal Health's programs.

Preventive Healthcare: Ongoing trainings are offered to providers throughout the year on required preventive healthcare services, including Medi-Cal for Kids & Teens, formerly known as Early Periodic Screening, Diagnosis and Testing (EPSDT) services for members under age 21, as well as appropriate medical record documentation and coding requirements. This includes training on existing CenCal Health data collection and reporting requirements, quality improvement programs, Population Health Management Program requirements, health education resources, and provider and member incentive programs. Such trainings are conducted at least once every two years.

Member Access: Education on member access, including compliance with appointment waiting time standards, and ensuring telephone, translation, and language access is available for members during hours of operation. Training also includes education on secure methods for sharing information between CenCal Health, providers, subcontractors, downstream subcontractors, members, and other healthcare professionals, as well as training on how to refer and coordinate care for members who need access to non-Covered Services.

Cultural Competency, Health Literacy, and Seniors and Persons with Disabilities: Trains providers on a continuing basis regarding clinical protocols and evidence-based practice guidelines. This process includes an educational program for providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to posting information on websites, as well as other methods of educational outreach to providers during an on-site in-service visit by Provider Services staff.

This training supports providers and staff in providing appropriate health care and services for our members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups. This includes but is not limited to education in the provider bulletin, on websites, through provider webinars, as well as outreach through on-site in-service visits by Provider Services staff.

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

Diversity, Equity, and Inclusion (DEI) Training: CenCal Health is committed to advancing health equity so that our communities thrive and achieve optimal health together. Training our staff and providing the same training opportunity to our network providers, subcontractors, and downstream subcontractors on the importance of diversity, equity, and inclusion is a critical component to advancing health equity for our communities. CenCal Health will make available DEI training that provides a comprehensive overview of our member demographics and foundational DEI concepts. Network providers will be offered this training biannually.

The goals of the training are to:

- Improve CenCal Health member outcomes by enhancing access to care, reducing health disparities, and improving the quality of care.
- Increase the ability of CenCal Health network providers to engage in culturally responsive care with populations faced with systemic disadvantages.
- Expand CenCal Health network providers' understanding of the Social Drivers of Health (SDOH) and how they shape inequities in health outcomes.

The training consists of three modules:

- **Understanding DEI through Health Inequities and Implicit Biases**
  This module dives into CenCal Health's diverse membership and the health inequities impacting our members. It examines barriers to care and explores the impacts of bias, while also offering strategies to effectively address implicit bias.
- **Exploring DEI through the Lens of Cultural Humility and CenCal Health's Diverse Member Population**
  This module offers valuable insights into the cultural groups within CenCal Health's service area, shedding light on their perspectives and approaches to health and healing. It distinguishes between cultural competency and cultural humility, highlighting how each concept informs approaches to healthcare delivery. Additionally, this module discusses the three tenets of cultural humility and offers guidance on applying cultural humility effectively in healthcare settings.
- **Connecting DEI to the Structural Determinants of Health**
  This module explores the root causes of health inequities among distinct segments of CenCal Health's membership, with a focus on structural and institutional racism. It also examines the connection between clinical outcomes and structural determinants of health.

Emergency Policies and Procedures: Providers will receive training on CenCal

Health's Emergency Policies and Procedures. This includes but is not limited to education in the provider bulletin, on websites, through provider webinars, as well as outreach through on-site in-service visits by Provider Services staff.

Medi-Cal for Kids & Teens Training: Medi-Cal for Kids & Teens, formerly known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT), guarantees all medically necessary services to children and youth under age 21 enrolled in Medi-Cal. This DHCS training aims to strengthen understanding and awareness of Medi-Cal for Kids & Teens among Medi-Cal managed care plan-enrolled providers and to increase access to children's health services. California's managed care plans, including CenCal Health, must ensure that all Medi-Cal network providers who provide such services for CenCal Health members under age 21 receive proper DHCS educational resources regarding Medi-Cal for Kids & Teens at least every two years.

Clinical Training Resources & Certification (formally known as CHDP Screening Trainings): On July 1, 2024, the Childhood Health and Disability Prevention Program (CHDP) was transitioned to align with the State of California's CalAIM goals and initiatives. As authorized by Senate Bill 184, this transition was made with the goal to "reduce administrative complexities, enhance the coordination of care and whole person care approach, and increase standardization of care" by merging care duties to managed care plans (MCPs), including CenCal Health. CHDP's goal is to provide preventive health, vision, and dental screenings to children under 21 enrolled in Medi-Cal. CenCal Health is offering training programs for healthcare providers. Staff who complete this training receive a Certificate of Completion for their records.

D-SNP Model of Care Training: CenCal CareConnect (HMO D-SNP) Model of Care (MOC) training provides participating providers with an overview of CenCal Health's road map for care management policies, procedures, and operational systems to support our dual members. This training provides an overview of the four core elements of CenCal CareConnect, including how CenCal Health coordinates care for members who are eligible for both Medicare and Medi-Cal. This training outlines the key elements of our care model, including member-centered care management, interdisciplinary care teams (ICTs), and provider collaboration to improve health outcomes.

Elements contained within the D-SNP Model of Care Training include:

- Special Needs Plan & Dual Special Needs Plan Overview
- Model of Care Goals and Benefits
- The Four Model of Care Components
    - 1: Description of the D-SNP Population
    - 2: Care Coordination
    - 3: D-SNP Provider Network
    - 4: Quality Measurement & Performance Improvement
- Providers' Role/Partnership

All participating care providers must complete this training annually as part of CMS compliance.

Biannual Mandatory Training: –
This training includes:

a. **Member Rights and Responsibilities:** Information on all member rights and responsibilities as specified in the contract between DHCS and CenCal Health;
b. **Population-Specific Training:** An educational program for providers regarding health needs to include, but not be limited to, the seniors and persons with disabilities (SPD) population, members with chronic conditions, members with specialty mental health service needs, members with substance use disorder needs, members with intellectual and developmental disabilities, and children with special health care needs; and
c. **Social Drivers of Health (SDOH):** Diversity impacts on members' health care.
d. **Medi-Cal for Kids & Teens (formerly known as EPSDT):** DHCS training that guarantees all medically necessary services to children and youth under age 21 enrolled in Medi-Cal receive increased access to children's health services.

Annual Mandatory Training: –
This training includes:

a. Compliance, Fraud, Waste, and Abuse (FWA) and HIPAA Privacy & Security Training
b. CenCal CareConnect (HMO D-SNP) Model of Care (MOC)
c. Culturally Competent Care, and Seniors and Persons with Disabilities Resources

Resources: There are a variety of educational materials and resources distributed to the providers by CenCal Health during each provider training and provided to all registered provider staff.

Attendee Tracking: For mandatory trainings, attendees are required to register for online webinars, which are then tracked for participation. If hosted in-person, attendees are given name badges and asked to sign an attendance sheet. Attendance and completion of trainings may also be tracked through a provider roster and attestation, which confirms completion.

Confidentiality and Privacy: No individual identifiable health information or protected health information is used or released during these training events. Blinded information may be used, or mock data may be created for demonstration purposes.

Monitoring: Attendees are requested to fill out an evaluation form after the training is completed. This allows the Provider Relations Department to assess the appropriateness of the program's subject matter, content, and method of presentation. Suggestions for new topics may be obtained from providers, staff, and internal committees such as the Provider Advisory Board, or may be the result of revised regulatory or procedural issues.

Reference Links:
CenCal Health Provider Training & Resources
www.cencalhealth.org/providers/provider-training-resources/

CenCal Health Provider Regulatory Training
www.cencalhealth.org/providers/provider-regulatory-training/

Welcome to the Network
www.cencalhealth.org/providers/welcome-to-the-network/

Medi-Cal for Kids & Teens Services
www.cencalhealth.org/providers/care-guidelines/medi-cal-for-kids-teens-services/

https://cencalhealthproviderlearningacademy.litmos.com/account/Login

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

B4: Advanced Health Care Directive

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

Members have the right to have an Advance Directive in place. CenCal Health members should fill out an Advanced Health Care Directive, as it is a simple form that tells doctors and loved ones exactly what type of care a patient wants at the end of their life or if they cannot speak for themselves. Providers should encourage members to complete an Advance Directive. Members can print it out, complete the form, and sign it. Then, they should give copies to their doctor(s), family, and/or friends. This will make sure that the members' values and choices are honored when or if they are unable to speak for themselves.

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

If members are not able to print the online form, we can send them a free copy. Please contact CenCal Health's Health Education Request Line at 1-800-421-2560, ext. 3126.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

B5: Community Resources

Please note that CenCal Health provides information regarding community resources as helpful information only. We do not intend to suggest that the organizations listed provide services that are covered benefits for our members. Thank you for your understanding.

The website findhelp.org maintains a social care network that makes it easy to find local, state, and federal resources available in our communities. Many of these resources are free or determined by income levels.

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

B6: Telemedicine Policy

Providers and practitioners offering telehealth services to CenCal Health members must adhere to specific guidelines and requirements in order to be reimbursed.

There is limited Medicare telehealth coverage as per Social Security Act §1834(m). When criteria are met, Medicare will be the primary payer. If Medicare coverage criteria are not met, then Medi-Cal will be the primary payer.

While telehealth can be a convenient and effective means of providing Covered Services, certain services are not suitable for remote delivery. Procedures requiring the in-person presence of a member, direct visualization or instrumentation of bodily structures, or sampling of tissues or medical device insertion/removal cannot be appropriately delivered via telehealth.

With the exception of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Providers (THPs), all providers can be reimbursed for consultations offered via telehealth. It's important to note that e-consults can only be initiated by the provider and not by the member. Additionally, providers, including

FQHCs, RHCs, and THPs, are eligible for reimbursement for brief virtual communication with members who are not physically present.

Starting January 1, 2024, providers offering applicable Covered Services through audio-only synchronous interactions must also offer the same service via video synchronous interactions. This change aims to preserve the member's choice and ensure access to comprehensive telehealth services.

To safeguard a member's right to in-person care, providers delivering services through video or audio-only synchronous interactions must take the following steps:

a. Offer the same services through in-person, face-to-face contact; OR
b. Facilitate a referral for in-person care, ensuring members do not need to independently contact another provider.

Prior to initiating Covered Services via telehealth, providers must inform members about the use of this modality and obtain their verbal or written consent. It is crucial to document this consent in the member's medical record, as it may be requested for review by the Department of Health Care Services.

During the consent process, providers must explain the following to members:

a. The member's right to access Covered Services in person if desired.
b. The voluntary nature of telehealth and the ability to withdraw consent at any time.
c. The availability of Non-Medical Transportation for in-person visits.
d. The potential limitations or risks associated with receiving Covered Services through telehealth, compared to an in-person visit.

Medicare Covered Telehealth Services

Starting October 1, 2025, members must be in an office or medical facility located in a rural area (in the U.S.) for most telehealth services. If members aren't in a rural health care setting, they can still get certain Medicare telehealth services on or after October 1, 2025, including:

a. Monthly End-Stage Renal Disease (ESRD) visits for home dialysis.
b. Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke, including in a mobile stroke unit.
c. Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder (including a substance use disorder) in their home.

Telehealth offers providers and practitioners the opportunity to provide Covered Services remotely, expanding access to care for patients. For additional details or guidelines, please contact Provider Relations at 805-562-1676.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

B7: Moral Objection

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

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

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

To make sure members choose a provider who can give them and their family the care they need, members can call the doctor, medical group, independent practice association, or clinic directly. They can also call CenCal Health at **1-877-814-1861 (TTY: CA Relay at 711)**. Members can ask if the provider can and will provide the services they need.

CenCal Health will make sure members and their family members can use providers (doctors, hospitals, clinics) who will give them the care they need. If members have questions or need help finding a provider, they can call CenCal Health at **1-877-814-1861 (TTY: CA Relay at 711)**.

Section C: Contracting and Credentialing

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

C1: Join the CenCal Health Network

Join us in our effort to provide quality healthcare to those in need. Please visit the CenCal Health website at www.cencalhealth.org to submit a **Provider Network Interest Form** or contact our Provider Relations Department at 805-562-1676, for guidance on the process.

All providers wishing to participate in CenCal Health's programs must successfully fulfill CenCal Health's credentialing requirements and meet the following criteria:

a. The provider must be Medi-Cal (PAVE) enrolled, where an enrollment pathway exists.
b. The provider's services must be available and accessible to CenCal Health members residing in San Luis Obispo and/or Santa Barbara counties.
c. The provider accepts CenCal Health's reimbursement for CenCal Health's Medi-Cal and Medicare (CenCal CareConnect) programs.
d. Have hospital privileges at a CenCal Health contracted hospital or ambulatory surgical center if they perform surgical procedures.

Provider Application and Validation for Enrollment (PAVE)

CenCal Health is required by federal law to ensure all contracted providers with a valid Provider Application and Validation for Enrollment (PAVE) pathway are enrolled in the DHCS Medi-Cal program via the PAVE portal**.** DHCS-enrolled providers are eligible to provide services to Medi-Cal Fee-for-Service (FFS) beneficiaries as well as CenCal Health Medi-Cal beneficiaries.

The state's PAVE portal is a web-based application designed to simplify and accelerate the state Medi-Cal enrollment process. Providers must utilize the portal to complete and submit applications, report changes to existing enrollments, and respond to requests for continued enrollment or re-validation. Please be sure to maintain current and accurate information about yourself and/or your group, as data submitted through PAVE comprises the database DHCS uses to understand the network of Medi-Cal providers in California. This is important even if you only see CenCal Health members and never submit claims for Fee-For-Service members.

If you are not enrolled with DHCS and have questions, please contact the Provider Relations Department, and our team will assist you with the enrollment process.

Provider Contracting and Credentialing

Providers interested in becoming a contracted provider of CenCal Health's Medi-Cal and Medicare (CenCal CareConnect) programs may submit a Provider Network

Interest Form via the CenCal Health website (www.cencalhealth.org), or contact the Provider Relations department at 805-562-1676, for guidance on contracting and credentialing.

Providers will be required to submit the following information:

- Type of services provided
- Service locations
- A complete credentialing packet
- Hospital and/or ambulatory surgery center privileges (as applicable)
- Proof of Medi-Cal/PAVE enrollment
- W-9 form
- All applicable NPIs

Reference Link:
DHCS PAVE Provider Enrollment
www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

C2: Provider Directory and Attestation of Practice Information

CenCal Health adheres to the Department of Managed Health Care's (DMHC) Senate Bill (SB) 137 for the Medi-Cal Provider Directory and CMS' Directory Model standards for the CenCal CareConnect Provider Directory. Provider directory standards allow members to receive and search for accurate, up-to-date information regarding physicians, hospitals, clinics, and other providers contracted with CenCal Health's network.

SB 137 and CMS Directory Model Document require CenCal Health to do the following:

- Publish and maintain accurate provider directories with information on contracting providers.
- Identify those providers who accept both Medicare and Medi-Cal.
- Verify Provider Directory information with contracted providers on a periodic basis.
- Update the online Provider Directory every 24 hours and the printed Provider Directory monthly.
- Ensure contracted providers notify the Health Plan when anything changes in their practice, including when they are no longer accepting new patients, a provider leaves or joins the practice, or the office hours or phone number change.

In an effort to provide members and providers with the most current information, CenCal Health's Provider Directory is updated on a routine basis. Providers need to verify and attest to the accuracy of their information via the CenCal Health provider roster at least every six months. Providers can request a pre-populated roster from CenCal Health that contains all data currently on file. Providers can submit changes, additions, and deletions from this pre-populated roster. Additionally, providers can download a blank roster template from the CenCal Health website and submit updates. The blank roster template can be found on CenCal Health's website at: www.cencalhealth.org/providers/provider-profile-and-practice-changes/

For any questions regarding attestation of your data, you can contact the Provider Relations Department at 805-562-1676 or send an email to: psrgroup@cencalhealth.org.

If you would like to obtain a printable copy of the Provider Directory, please visit our website at www.cencalhealth.org/providers/search-provider-network or contact the Provider Relations Department for assistance.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

C3: Credentialing and Recredentialing

As part of our Quality Improvement and Health Equity Program, CenCal Health maintains a comprehensive credentialing and recredentialing process to ensure that all providers listed in our network meet federal, state, and organizational standards for quality and safety, and in accordance with 42 CFR 422.204 and 438.214, as applicable. Credentialing standards are based on federal and California state requirements, which include, but are not limited to, the Department of Health Care Services (DHCS) APL 22-013, the California Department of Managed Health Care (DMHC), and the National Committee for Quality Assurance (NCQA). Providers are required to maintain active credentials with CenCal Health and will be required to complete the re-credentialing process at least every 36 months.

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

Provider Types that Require Credentialing

The following is a list of provider types that require credentialing:

- MD/DO (Medical Doctor/Doctor of Osteopathic Medicine)
- DC (Doctor of Chiropractic)
- DPM (Doctor of Podiatric Medicine)
- OS (Doctor of Oral Surgery)
- PsyD (Doctor of Psychology)
- Physician Executive

- PA/PA-C (Physician assistant)
- NP/NP-C (Nurse Practitioner)
- CRNA (Certified Registered Nurse Anesthetist)
- CNM / LM (Certified Nurse Midwife/Licensed Midwife)
- Allied Health Providers (e.g., PTs, OTs, ODs, etc.)
- Organizations (e.g., Clinics, Hospitals, Community Health Worker, DME agencies, home health, etc.)
- Dentists
- Behavioral Health Providers (e.g., psychiatrists, LCSWs, LMFT, LPC, etc.)

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

CenCal Health acknowledges receipt of credentialing applications and notifies applicants of any missing or incomplete information as part of the application review process. Once an application is deemed complete, credentialing review is generally completed within 60 calendar days. This timeframe applies to the credentialing review process and does not include contracting, enrollment, onboarding, or other post-credentialing activities that may be required before participation becomes effective.

The following steps are required to complete the credentialing and recredentialing process:

a. Complete the Credentialing Application, Provider Information Form, all required plan-level Addendums, Taxpayer Identification Form (W-9), and attach copies of all information requested below, as applicable:
    i. Copy of current medical license or business license.
    ii. Copy of DEA.
    iii. Copy of professional liability insurance (malpractice) face sheet, including the expiration date and amount of coverage. Copy of general liability insurance face sheet, including the coverage amount.
    iv. Completed and signed attestation.
    v. Signed supervisory letter for Nurse Midwives, Physician Assistants, and Nurse Practitioners. If applicable, a signed Behavioral Health Board Supervisory letter for associate behavioral health providers.
    vi. Signed release of information.
    vii. Signed copy of "New Provider Orientation" attestation as related to the regulatory provider training materials.
    viii. Other verifications, as required by provider type.
b. CenCal Health will verify information via a primary source verification.
c. CenCal Health will screen providers against applicable federal and state sanctions and exclusion sources, including the National Practitioner Data Bank (NPDB), Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), DHCS Medi-Cal Suspended and Ineligible Provider List, and other sources as applicable.

d. Credentialing applicants are reviewed by the CenCal Health Chief Medical Officer (CMO), Medical Director, Designee, or by the Peer Review and Credentialing Committee (PRCC), as applicable.
e. Primary Care Providers and certain other provider types may also have a site review before the credentialing process is finalized. Primary Care Providers and other applicable providers must achieve a passing score on the Facility Site Review and the Medical Record Review. For further information, refer to the Facility Site, Medical Record, and Physical Accessibility Reviews section C5.
f. As part of the recredentialing process, CenCal Health also considers data derived from practice experience within the organization, as well as complaints, potential quality issues, and member satisfaction scores.
g. Providers are recredentialed at least every 36 months; additional review may occur more frequently when warranted by regulatory requirements, credentialing findings, quality concerns, or PRCC recommendation.
h. Notification of initial credentialing decisions and adverse credentialing decisions will not exceed 30 calendar days.

To ensure that CenCal Health has obtained correct information and makes fair credentialing and recredentialing decisions, practitioners are afforded certain rights during the credentialing and recredentialing process, including:

a. The right to review information obtained to support their credentialing application.
b. Correct erroneous information within 30 days of the request.
c. Receive the status of their credentialing or recredentialing application, upon request.

To review information obtained through the credentialing process, correct erroneous information, or receive the status of a credentialing or recredentialing application, submit the request via email to providercredentials@cencalhealth.org.

CenCal Health also conducts continuous monitoring to ensure ongoing compliance. This includes:

a. Sanctions and exclusions against federal and state databases.
b. Quality of care reviews, including complaints, grievances, and utilization patterns.
c. Verification of continued licensure, sanctions and exclusions, and other credentialing requirements, as applicable.

CenCal Health does not base credentialing standards on an applicant's race, ethnic/national identity, color, marital status, religious creed, ancestry, national origin, physical or mental disability, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes. Additionally, the PRCC membership is heterogeneous, and all members are required to sign a non-discrimination statement. CenCal Health proactively prevents discrimination through the credentialing and recredentialing process, as well as monitoring the credentialing and recredentialing process for discriminatory practices.

In some instances, the credentialing and recredentialing process may be delegated, wholly or in part, to another entity with oversight by CenCal Health to ensure the same standards are being met.

Supervising Physician Requirements
A supervising physician may oversee no more than four non-physician medical practitioners during any single work shift, in accordance with state and federal regulations.

CenCal Health may credential more than four non-physician medical practitioners per one full-time equivalent (FTE) supervising physician at a clinic; however, it is the responsibility of both the clinic and the supervising physician to ensure that no more than four are supervised at the same time during any shift.

CenCal Health routinely monitors supervising physician ratios to ensure ongoing compliance with applicable state and federal supervision requirements.

The supervising physician must be either:

- A contracted provider, or
- Part of a contracted group/entity that is responsible for billing and compliance.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

C4: Credentialing Contractual Requirements

As part of the contract with CenCal Health, providers agree to comply with several key requirements related to credentialing and regulatory standards. These include:

- You and any providers affiliated with your practice must be, and remain, properly licensed in the State of California.
- Providers must maintain good-standing and active enrollment with Medi-Cal (PAVE). Failure to maintain said requirement could result in delayed reimbursements and/or terminations from CenCal Health's provider network.
- You must maintain compliance with all applicable legal, professional, and regulatory standards as a participating Medi-Cal and/or Medicare provider.
- Additionally, provider types for which hospital privileges are applicable must maintain active medical staff privileges or other appropriate admitting arrangements in accordance with CenCal Health credentialing requirements.

Exclusions from Federal Programs
Providers who are excluded, suspended, terminated, or otherwise ineligible to participate in Medicare or Medi-Cal, including individuals or entities identified on the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) or the

DHCS Medi-Cal Suspended and Ineligible (S&I) Provider List, may not provide services to CenCal Health members.

Credentialing Notification Requirements

You are required to notify CenCal Health in writing within 14 calendar days if any of the following occurs for you or any provider affiliated with your practice:

- Revocation, suspension, restriction, or non-renewal of any license, certification, or clinical privileges.
- Any peer review action, corrective action proceeding, inquiry, or investigation.
- Any malpractice or governmental action, or allegations concerning a provider's qualifications or ability to practice.
- Submission of a report to a state licensing board, regulatory body, or the National Practitioner Data Bank involving credentialing or peer review action
- Sanctions, investigations, or exclusions related to Medicare or Medi-Cal.
- Placement on, or notification of pending placement on, the OIG LEIE, DHCS Medi-Cal Suspended and Ineligible Provider List, or any other federal or state exclusion database.
- Any material change in the credentialing information previously submitted to CenCal Health.
- Any incident that may affect a provider's license, certification, or ability to meet contractual obligations.

Failure to Meet Credentialing Standards

If a provider no longer meets CenCal Health credentialing requirements, including loss of required licensure, certification, participation eligibility, or privileges, the provider may be subject to suspension, termination, or other action and may not provide covered services except as otherwise permitted by applicable law, regulation, contractual obligation, or continuity-of-care requirements.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

C5: Facility Site, Medical Record, and Physical Accessibility Reviews

CenCal Health conducts Facility Site Reviews (FSRs), Medical Record Reviews (MRRs), and Physical Accessibility Reviews (PARs) for all Primary Care Provider (PCP) sites as a condition of participation in CenCal Health's provider network. These reviews support compliance with DHCS, CMS, and NCQA accreditation standards for quality, safety, and access.

Facility Site Reviews (FSRs)
FSRs are conducted using the DHCS Medi-Cal Managed Care Full Scope Site Review Survey Tool. For Medicare Advantage (D-SNP) compliance, FSRs additionally align with CMS and NCQA standards for provider site readiness and member accessibility. Key components include:

- On-site inspection and staff interview.
- Evaluation of:
    - Administrative policies
    - Infection control and safety procedures
    - Emergency preparedness
    - Exam room adequacy and equipment
    - Cleanliness and signage

A passing FSR score is required before member assignment can occur. FSRs are conducted:

- Upon site activation (initial credentialing),
- Every three years, or
- More frequently based on prior deficiencies or relocation.

Medical Record Reviews (MRRs)
MRRs evaluate the completeness, quality, and compliance of documentation for a randomly selected sample of adult and/or pediatric records, based on practice type. MRRs assess:

- Legibility and organization
- Legal documentation standards
- Preventive care documentation
- Evidence of care coordination
- Member rights documentation

MRRs must meet DHCS benchmarks and are required for initial credentialing and triennial recredentialing.

Scoring, Deficiencies, and Corrective Action Plans (CAPs)
FSRs and MRRs are scored using tools mandated by DHCS. Critical element deficiencies automatically require a Corrective Action Plan (CAP). CAPs must be implemented and verified within state-required timeframes.

- Reviews are conducted by DHCS-certified nurse reviewers from CenCal Health.
- Reviewers provide technical assistance and support CAP implementation where needed.

Physical Accessibility Reviews (PARs)
PARs are required under DHCS and CMS guidelines to ensure access for Seniors and Persons with Disabilities (SPDs) and to meet ADA and NCQA accessibility standards.

PARs are conducted:

- At all PCP sites during the initial FSR and triennial

- At specialist, CBAS, and ancillary sites that serve high volumes of SPDs

PARs assess:

- Parking accessibility
- Exterior and interior building navigation
- Elevators (if applicable)
- Accessible exam rooms
- Restroom accommodations
- Availability of:
    - Height-adjustable exam tables
    - Accessible weight scales

Collected PAR data informs directory accessibility disclosures and supports network adequacy and health equity requirements.

Provider Responsibilities

Providers are required to:

- Maintain readiness for FSR, MRR, and PAR compliance.
- Notify CenCal Health immediately if:
    - There is a change in PCP assignment or employment, or
    - The practice relocates or expands to a new site.
- Complete initial, periodic, and interim surveys timely
- Resolve CAPs timely

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

Reference Links:

To access tools, checklists, and sample audit materials for preparing for an FSR or MRR, visit:
www.cencalhealth.org/providers/facility-site-review-and-medical-record-review/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

C6: Access to Care Standards

CenCal Health is committed to complying with and monitoring member access and availability standards established by the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). These standards are designed to ensure that Medi-Cal and Medicare beneficiaries can obtain timely

appointments, reach providers by phone, and access interpreter services when needed. Please refer to the table below for a summary of the applicable regulations.

CenCal Health and DHCS conduct appointment availability and after-hours access surveys at least annually. The survey methodology, format, and targeted provider types may vary based on guidance from DHCS or CMS. Participation in these surveys and adherence to established standards are important and mandatory for all contracted providers. How your staff answers the questions will determine whether a deficiency exists. Make sure that staff are familiar with your clinic's policies and procedures. This will help collect responses that are consistent with your clinic's standards of care.

Additionally, providers are required to notify the Provider Relations Department of any changes to their practice information to maintain the accuracy of the Provider Directory.

We value the ongoing partnership with our providers as we work together to support the delivery of high-quality care to our members. For any questions, please contact the Provider Relations Department at 805-562-1676 or email psrgroup@cencalhealth.org.

For Medi-Cal Members, appointment standards include:

Type of Care	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

For CenCal CareConnect members, appointment standards include:

Type of Care	Standard Time Frame
Emergency Services	Immediately

Urgent Care Services	Immediately
Non-emergency but medically necessary services (including behavioral health)	Within 7 business days
Routine and Preventive Care	Within 30 days

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

C7: Terminating a Provider

In the event that a provider terminates their agreement with CenCal Health, we must make every effort to ensure our obligations to the State and our members' care are met, including ensuring that members are notified within an appropriate timeframe and reassigned to another CenCal Health participating provider, when necessary, to ensure continuity of care.

As a network provider, it is important to ensure that you notify CenCal Health in writing at least 60 days prior to any changes to your practice that may result in the termination of your agreement with CenCal Health. Examples of where termination may be appropriate include, but are not limited to, instances when a provider is moving outside our service area, retiring, or resigning. CenCal Health is required to notify DHCS of some provider terminations.

In accordance with the agreement held between a provider and CenCal Health, and with all state, federal, and other applicable laws, providers must also ensure access to members' records and other information necessary to ensure coordination and transfer of care to another provider. Providers are obligated to cooperate and assist with ensuring our members' needs are met during this time, and that any other activities and responsibilities following termination are honored.

CenCal Health will acknowledge your written notice of termination with a receipt confirming the notice was received. Additionally, a member of the Provider Relations team will contact you to obtain valuable feedback regarding your termination and to identify opportunities for improvements to CenCal Health's programs and services.

Section D: Provider Responsibilities

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D1: Role of the Primary Care Provider (PCP)

The Primary Care Provider (PCP) acts as a central point of contact for managing a member's healthcare needs, providing preventive care, managing chronic conditions, coordinating specialty care, and ensuring quality of care in accordance with prevailing, evidence-based medical standards. The PCP serves as the medical home of healthcare services for CenCal Health members and is responsible for the structuring and delivery of healthcare to their assigned members.

CenCal Health's model of care (for both Medi-Cal and CenCal CareConnect) is built around the PCP. The PCP is the center of a multidisciplinary team coordinating services rendered by other physicians and/or providers to meet the member's healthcare needs.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D2: Responsibilities of the Primary Care Provider (PCP)

PCP responsibilities include, but are not limited to:

a. Provide care for the majority of healthcare issues presented by the member, including but not limited to: preventive, acute, and chronic healthcare.
b. 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.
c. Case manage assigned members to ensure continuity of care, facilitate access to appropriate health services, reduce unnecessary referrals to specialists, minimize inappropriate use of the emergency department, maintain appropriate use of pharmacy benefits, and identify appropriate health education materials and interventions.
d. Assure access to care 24 hours a day, seven days a week, including telephone access, accommodations for urgent care, performance of procedures, and inpatient rounds.
e. Coordinate and direct appropriate care for members, including:
    i. Initial Health Appointments.
    ii. 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).

iii. Second opinions.
iv. Consultation with referral specialists.
v. Follow-up care to assess results of primary care treatment regimen and specialist recommendations.
vi. Special treatment within the framework of integrated, continuous care.

f. Screen members for mental health and substance use difficulties, provide treatment within scope of practice, and assist the member with referrals to appropriate treatment providers. Coordinate the authorization of specialist and non-emergency hospital services for members.
g. Contact and follow up with the member when the member misses or cancels an appointment.
h. Record and document information in the member's medical record, including:
    i. Member office visits, emergency visits, and hospital admissions.
    ii. Problem lists, including allergies, medications, immunizations, surgeries, procedures, and visits.
    iii. Efforts to contact the member.
    iv. Treatment, referral, and consultation reports.
    v. Lab and radiology results ordered by the PCP.
    vi. Authorization to Release Information to and from the member's mental health and substance use provider.
i. Make reasonable attempts to communicate with the member in the member's preferred language, using available interpretation or translation services.
j. If the member is currently receiving mental health or substance abuse treatment services, coordinate the member's care with the existing mental health or substance use provider.

Additional responsibilities for PCPs who see CenCal CareConnect members include:
Coordination of Care:

a. Participate in the development of individualized care plans to help ensure the member's experience is a seamless coordination between Medicare and Medi-Cal benefits.
b. Manage Dual Eligibility: Understand and navigate the requirements of both Medicare and Medi-Cal to optimize patient care and coverage.
c. Follow Care Transition Protocols: Participates in care transition activities and collaborates with the health plan, care managers, and other providers regarding admissions, discharges, and other transitions in care.
d. Preventive and Chronic Condition Care.
e. Participate in Quality and Preventive Care Measures specific to the Medicare line of business and quality standards.
f. Participate in Care Management meetings, such as interdisciplinary care team (ICT) meetings, with MCP care managers to discuss specific patient cases, review Health Risk Assessment (HRA), coordinate and review individualized care plans (ICP), and address any barriers to care.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D3: Hospital Service Obligations for CenCal Health Members

Licensing

The Hospital shall be:

- Licensed as a general acute care hospital in accordance with the requirements of the California Health Facilities Licensure Act (Health and Safety Code, Sections 1250 and following) and the regulations thereunder.
- Maintain certification as a hospital provider by Medicare and Medi-Cal.
- Be accredited by a nationally recognized accrediting body, such as the Joint Commission, to provide Covered Services.
- Maintain facilities, staffing, and operational readiness to provide covered inpatient and outpatient services to CenCal Health members.

If the Hospital provides distinct part skilled nursing beds, the Hospital shall be licensed as a general acute care hospital with distinct part skilled nursing beds in accordance with Section 1250.8 of the Health and Safety Code and the licensing regulations contained in Titles 22 and 17 of CCR. If the Hospital ceases to provide this service for any reason, it must notify CenCal Health 90 days prior to the cessation of the availability of these services.

Services Provided by Hospital

The Hospital shall provide benefits to members, subject to the availability of appropriate facilities and services. Members are entitled to receive inpatient services when ordered by a member's responsible physician or other qualified health practitioner, and said services should be provided in accordance with regulations as set forth in 22 CCR Section 51301. Services to be rendered are subject to exclusions, limitations, exceptions, and conditions as agreed to by the Hospital and CenCal Health. CenCal Health members must receive the same quality of care and access to services as all other patients, without discrimination, and in accordance with all applicable laws and regulations.

Services Not Covered and Not Compensated

The Hospital shall not be obligated to provide members services that are not covered under CenCal Health's contract with the state, and CenCal Health shall not be obligated to compensate the Hospital for uncovered services.

Services Rendered on Basis of Availability of Facility

The Hospital shall not discriminate against CenCal Health's members in connection with its admission policies or practices. Admission of members to the Hospital for care and treatment must be based upon the severity of medical need and the availability of

Hospital facilities and Hospital services. The decision as to whether or not a member requires specific medical care or hospital services is a professional medical decision to be made by the member's attending physician in accordance with applicable medical staff rules and regulations.

Additionally, the Hospital is expected to use its best efforts to maintain its current facilities, equipment, and patient service personnel (as well as allied health personnel) to meet its obligation to provide covered benefits to CenCal Health's members. However, the Hospital is not obligated to provide said members with inpatient, outpatient, or emergency services that are not maintained by the Hospital due to religious or other reasons.

Standard of Care
Members shall be entitled to receive hospital care in accordance with recognized hospital, professional, and applicable state licensing laws and regulations.

Emergency Services
Emergency Services, as defined in the Hospital's Network Provider Agreement, means those services required for alleviation of a medical or behavioral health condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the patient's health (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious risk of harm to self or others due to a mental health or substance use disorder.

Emergency Services, both in the emergency department and for inpatients who require immediate treatment for unexpected conditions, require the professional care of a physician who is immediately available on or near Hospital premises. The Hospital must arrange for such services to be available to all patients, including CenCal Health's members, requiring such services by a contract with physicians who have agreed to provide required emergency services on an independent contract basis. CenCal Health is responsible for payment for treatment and services rendered by these physicians.

CenCal Health's members are permitted to obtain emergency services immediately at the nearest provider when the need arises. The Hospital shall provide Emergency Services to each member who presents at the emergency department and who, within the judgment of the attending physician, requires such Emergency Services. CenCal Health is responsible for payment for treatment and emergency room facility services rendered by the Hospital.

Prescribed Drugs Under Emergency Circumstances
When the course of treatment provided to a member under emergency circumstances requires the use of drugs, a sufficient quantity of drugs (including for the treatment of a mental health or substance use condition) shall be provided to the member to last until they can reasonably be expected to have a prescription filled.

Discharge Summaries and Emergency Room/Urgent Care Center, or Treatment/Examining Room Reports
The Hospital shall prepare a written discharge summary within30 days of the CenCal Health member's discharge and shall use best efforts to send a copy of said summary to the member's Primary Care Provider (PCP) or case manager. The Hospital shall also prepare a written treatment summary of services, including mental health and substance use services rendered in the Hospital's emergency department, urgent care center, or treatment/examining room within 30 days of treatment of a member and shall use best efforts to send a copy of said summary as indicated above and consistent with all applicable federal and state confidentiality and patient consent requirements. Said discharge summaries and treatment summaries shall contain information ordinarily prepared by the Hospital and provided to third-party payers at the time a bill for service is submitted, and are important for the member's PCP to receive for continuity of care issues and optimum case management. Failure by the Hospital to send such summaries to the PCP or case manager may result in CenCal Health's denial of payment for services rendered *unless another means of communication to inform said physicians of the services rendered to CenCal Health's members is agreed to by the parties*.

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

Miscellaneous Requirements
The Hospital agrees to:

- Verify a CenCal Health member is eligible for benefits under the program indicated on their identification card.
- Comply with CenCal Health's Utilization Management policies and procedures.
- Use its best efforts to ensure that discharge planning is performed for all CenCal Health members who are admitted to the Hospital in as expeditious and timely a manner as is possible, and to attempt to place these members, who otherwise qualify for placement in skilled nursing facilities, in alternative non-institutional settings whenever possible.
- Permit the member to be visited by their domestic partner, the children of the member's domestic partner, and the domestic partner of the member's parent or child.
- Assure that domestic partners are treated on an equal basis with spouses, including coverage of dependents of domestic partners as with spouses.
- Work with CenCal Health to ensure that the cultural and linguistic needs of CenCal Health's members are met. Further information on Providing Culturally

Competent Care, go to Section D, D7 in Member Services of this Provider Manual.

Care Coordination for Carved out Behavioral Health Services for Medi-Cal Members Only

Care of CenCal Health Medi-Cal members who present to the emergency department with a mental health emergency must be coordinated with County Behavioral Health Services, which covers Psychiatric inpatient services. CenCal Health members, who, after stabilizing a mental health or substance use emergency, do not require inpatient admission, must be provided with a referral to appropriate mental health and substance treatment services.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D4: PCP Requests for Member Reassignment

The goal of CenCal Health is to create the most beneficial relationship between the member and provider. If you feel that this relationship has been compromised, due to one of the reasons (listed below), we kindly request that you describe in detail the circumstance(s) and attach supporting documentation to describe the efforts made to address the issue with the patient. As a reminder, member reassignment should be the last resort. In order to consider your request, please complete the following steps:

a. Complete Member Reassignment Request via the Provider Portal.
    i. Select "PCP Reassignment Request" from the list of forms. Enter your Provider ID# (your NPI) and the Member Client ID# (CIN). If the member is not currently eligible or is not assigned to you, you will receive an error message.
    ii. Select a reason for the reassignment request (selections include appropriate contractual reason).
    iii. Include supporting information in the "Provider Remarks" section (dates, examples of how the member is non-compliant or abusive (be detailed), information on how you have tried to work with the member).
    iv. When complete, click the "Submit" button on the form.
b. Send a copy of the written notification to the member. The purpose of sending written notification is to advise the member that you are taking the steps necessary to begin the reassignment process with CenCal Health. A letter must be sent for each member you seek to have reassigned (reassignment of one person from a family does not automatically reassign the entire family).

The following are examples of appropriate reasons to request reassignment of a member:

- **Medication Seeking:** Member requests for non-medically necessary medications and/or is attempting to obtain substantially more medication than is warranted.
- **Non-Compliance with Case Management/Treatment Plan:** Member refuses to comply with case management or your recommended treatment, thereby endangering their health or significantly aggravating a medical condition.
- **Abusing ER Services:** Only approved for extraordinary cases of deliberate circumvention of case management and will require extensive documentation.
- **Failure to keep scheduled appointments:** List dates the member no-showed for appointments without calling to cancel, despite reminder calls/appointment verification (at least five separate dates in the past rolling year from the date the reassignment request was initiated.
- **Abusive and Disruptive Behavior:** List specific incidents/dates and include quotations. If the member poses an immediate threat to self or others, call the appropriate authorities if necessary.
- **Ineffective relationship:** Describe how there is an irremediable breakdown of the physician/patient relationship, such that ongoing effective communication and patient care are impossible.
- **Alleged/Actual Member Fraud or Theft:** Describe how the member fraudulently sought or received Covered Services. Describe how the member has committed theft from the practice.
- **Other:** Other circumstances, supported by documentation in which the provider believes the member should be reassigned.

The following are examples of inappropriate reasons to request reassignment of a member:

- The member's disagreement with the recommended course of treatment, where such disagreement does not endanger the health of the member or significantly aggravate a medical condition. Members have the right to refuse treatment and obtain a second opinion.
- The member has filed a complaint regarding the provider or the provider's office staff.
- Minor disruptive or verbally inappropriate behavior to the provider or office staff. If CenCal Health can obtain case management services to support the member in avoiding disruptive or verbally inappropriate behavior, to ensure effective case management.
- When a member moves to another area of the county and needs a PCP in closer proximity to their new home, the member must initiate a re-selection through a Member Services Representative. If you know a member has moved, please contact CenCal Health Member Services and be prepared to provide the member's new address or phone number.
- A change to a special class is needed: For those members who move to a skilled nursing facility by the first day of the month and are expected to remain there for more than 30 days, for members who have moved out of the county, and for

members with certain other circumstances, inform the Member Services Department at 877-814-1861.

CenCal Health will process your request by completing the following steps:

a. Review of the Request for Member Reassignment for completeness, accuracy, and appropriate details.
b. Documentation of the member's version of the events.
c. Medical Director reviews and makes a decision to approve, defer, or deny the request.
d. Verbal or written notification of the outcome to the requesting provider.
e. Notification of the outcome to the member.

What to do while you wait for the outcome of the request?
The member will remain assigned to your practice until CenCal Health approves the request. If the request is approved, the member remains assigned until the effective date identified in the letter notifying you of the approval. Until that date, you are required to ensure access to care by providing it yourself or referring the member out to another provider. Ensuring access to care includes prescribing or writing refills for any medically necessary prescriptions for the member. In addition, you are responsible for authorizing any specialty care services that the member may require until the effective date of reassignment.

If approved, when is the request effective?
If your request is approved, the effective date of the reassignment is typically the first day of the month following the date your request is approved and processed by CenCal Health. However, CenCal Health may determine a later effective date to allow adequate time for internal processing and for contacting the member so that they may select another Primary Care Provider.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D5: Medical Records

All contracted providers must maintain complete, accurate, and timely medical records for all CenCal Health members in compliance with federal and state laws, including Medicare, Medi-Cal, HIPAA, 42 CFR Part 422, the Knox-Keene Act, and NCQA documentation standards.

Each primary care office is responsible for maintaining adequate medical records of patient care, including encounter data. Records must be maintained in accordance with applicable federal and state privacy laws. All medical records must be maintained in a manner consistent with professional practices and prevailing community standards.

Providers are required to maintain records for 10 years after termination of agreement with CenCal Health, including the period required by the Knox-Keene Act and Regulations, and Medicare and Medi-Cal programs.

If an unauthorized disclosure of member information occurs, providers are to notify CenCal Health immediately upon discovery by calling CenCal Health's Toll-Free 24-Hour Compliance Hotline at 866-775-3944.

Records Copying Surcharges
All providers are expected to furnish any medical or other records requested by CenCal Health during the usual course of business at the provider's expense, including but not limited to those for utilization review, case management, quality programs, claims adjudication, grievances and appeals, investigations, member records following termination, or other activities CenCal Health must conduct to administer its programs and benefits, or at the request of any governmental agency.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D6: Resources for Seniors and Persons with Disabilities

Members of CenCal Health have the right to have full access to health plan benefits, regardless of age or disabilities. We want to assist providers in meeting this obligation and ensure that members can receive the healthcare services they need. Below is information about our services and community resources that provide services to seniors and persons with disabilities.

- *Interpreter Services:* Telephonic and video interpretation are available through our vendor, Certified Languages International. Face-to-face interpreters may be available when criteria are met for American Sign Language, Spanish, and Mixteco, but require pre-scheduling. For face-to-face interpreters, we ask that the provider call in the request to CenCal Health's Member Services Department at least five business days prior to the appointment date. However, providers are encouraged to make the request as early as possible to increase the likelihood of a face-to-face interpreter being available to cover their request.

- *Certified Languages International (CLI) offers access to telephonic and video interpreters 24/7* for our members at no cost to the provider or the member. Telephonic interpreters provide assistance in over 230 languages and video remote interpreters are available for over 20 languages. Many of these languages, including Spanish and ASL, are available on demand without the need for pre-scheduling. Instructions for accessing CLI interpreters are in the Provider Manual and on our website in the Language Assistance Program Resources, Section N.

- *Hearing Impaired:* Contact Member Services by using the California Relay Service at 711.

CenCal Health's Member Handbook and CenCal CareConnect's (D-SNP) Member Handbook are also available in large print and other formats upon request by calling the Member Services Department at 877-814-1861.

Providers should inform members to reach out to a CenCal Health Member Services Representative by calling 877-814-1861 for information on wheelchair accessibility and assistance with access issues.

Reference Link:

Cultural & Linguistic Resources

www.cencalhealth.org/providers/cultural-linguistic-resources/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D7: Providing Culturally Competent Care

CenCal Health does not discriminate against individuals based on race, ethnicity, national origin, religion, age, mental or physical disability or medical condition, genetic information, sexual orientation, or gender, including gender identity and gender expression.

CenCal Health ensures that services are provided in a culturally competent manner and promotes equitable access to all enrollees, including the following:

a) People with Limited English Proficiency (LEP) or reading skills.
b) People of ethnic, cultural, racial, or religious minorities.
c) People with disabilities.
d) People who identify as lesbian, gay, bisexual, or other diverse sexual orientations.
e) People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
f) People living in rural areas and other areas with high levels of deprivation.
g) People otherwise adversely affected by persistent poverty or inequality.

Culturally competent care is the ability of healthcare providers and organizations to understand and respond effectively to the cultural and language needs of each individual patient.

Cultural competence requires organizations and their personnel to:

- Value diversity
- Assess themselves
- Manage the dynamics of difference
- Acquire and institutionalize cultural knowledge

- Adapt to diversity and the cultural contexts of individuals and communities served

Adapted from Cross et al., 1998 and U.S. Department of Health and Human Services, Office of Minority Health, 2000.

The racial, ethnic, and sociocultural diversity of patients may create challenges as you strive to deliver high-quality services. Personal factors can consciously or unconsciously influence how we interact with patients. Becoming self-aware of one's own attitudes, beliefs, biases, and behaviors — and recognizing that they can impact patient care — can help providers improve their patients' quality of care, access to care, and health outcomes.

U.S. Department of Health and Human Services' Office of Minority Health, 2013.

Cultural Competence in Practice

Interpreter Services: CenCal Health members may request the use of telephonic or video Interpreter Services. For details about accessing Interpreter Services for patients, see Section N of this Manual.

Gender/Sexuality Non-Discrimination: Providers should strive to normalize the inclusion of all gender identities and sexual orientations within the practice setting, create inclusive service delivery systems, and use gender-neutral language and labels.

CenCal Health is required to treat members consistent with their gender identity. CenCal Health provides transgender members with the same level of healthcare benefits that are available to cisgender (non-transgender) members, including all medically necessary services and gender affirming care.

Health Literacy: Understanding health information can be difficult for everyone, and particularly for those with poor reading skills, those with Limited English Proficiency (LEP), older adults, and those with "information overload." Patients may not understand medication instructions, when to schedule follow-up, etc. For Health Literacy Resources to assist in effective patient communication, see Section P, P1 of this Manual.

Education: All CenCal Health contracted providers are provided training on the importance of Culturally Competent Care in the Health Care System, Health Literacy, Seniors and Persons with Disabilities (SPD), and Diversity, Equity & Inclusion (DEI). Please visit the Provider Regulatory Training web page at www.cencalhealth.org/providers/provider-regulatory-training/ for additional resources and learning opportunities to integrate into your practice.

Reference:

42 CFR 422.112: Ensuring equitable access to Medicare Advantage (MA) Services

Reference Links:

Cultural & Linguistic Resources

www.cencalhealth.org/providers/cultural-linguistic-resources/

Cultural Competency & Health Literacy
https://www.cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-and-health-literacy/www.cencalhealth.org/providers/provider-regulatory-training/

Provider Regulatory Training
www.cencalhealth.org/providers/provider-regulatory-training/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D8: Disease Surveillance

All CenCal Health contracted providers are required to actively participate in public health disease surveillance and reporting activities as mandated by local, state, and federal law, including obligations under the California Code of Regulations (CCR), California Health and Safety Code, Centers for Medicare & Medicaid Services (CMS), and applicable directives issued by the Department of Health Care Services (DHCS).

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

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

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

Reference Links:

CenCal Health Policy & Procedure HS-UM28 Disease Surveillance

Reporting to Local Health Authority
www.cdc.gov/nndss/about/index.html

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D9: Compliance with Statutes and Regulations

Providers shall comply with all applicable federal, state, and local law. Providers must also comply with regulations, regulatory program requirements, and regulatory contractual obligations set forth by regulatory agencies having jurisdiction over CenCal Health and/or providers.

This includes, without limitation:

- Affordable Care Act (ACA)
- Americans with Disabilities Act (ADA)
- California Code of Regulations (CCR)
- California Confidentiality of Medical Information Act
- Centers for Medicare and Medicaid Services (CMS) Final Rules
- Code of Federal Regulations (CFR)
- Fraud and abuse prevention and detection laws, including, but not limited to:
    - Anti-Kickback Statute (AKS)
    - False Claims Act (FCA)
    - Stark Law (Physician Self-Referral)
- Health Information Technology for Economic and Clinical Health (HITECH) Act
- Laws governing the use of federal funds.
- Privacy and security laws, including, but not limited to:
    - Health Insurance Portability and Accountability Act (HIPAA)
    - California Consumer Privacy Act
    - California Privacy Rights Act
- Regulations and requirements of the following regulatory agencies:
    - California Department of Managed Health Care (DMHC);
    - California Department of Health Care Services (DHCS); and
    - Centers for Medicare & Medicaid Services (CMS)
    - California Department of Health Care Access and Information
- Social Security Act (SSA)
- Telephone Consumer Protection Act (TCPA)

While CenCal Health will make efforts to inform network providers of significant changes, providers are expected to review and act upon regulatory changes. This includes, yet is not limited to:

- All County Welfare Directors Letters (ACWDL)
- Bulletins
- Policy Guides
- All Plan Letters
- All Licensee Letters
- Memoranda
- Medi-Cal Eligibility Division Information Letters (MEDIL)
- Medicare Managed Care Manual
- Medi-Cal Provider Manuals

CenCal Health requires providers to comply with all terms and conditions of its contracts with DHCS and CMS to operate Medi-Cal and D-SNP lines of business. CenCal Health maintains ultimate responsibility for oversight and monitoring of its network providers' compliance with regulatory agency contractual obligations.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D10: Data Reporting

Accurate and timely provider data is critical to CenCal Health's operations and is used to support claims processing, member services, regulatory compliance, network adequacy analysis, and care coordination.

Providers are required to submit all necessary reports and data to enable CenCal Health to meet applicable state and federal legal and contractual reporting obligations. This includes, but is not limited to, reporting requirements set forth by the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS), as well as data related to Covered Services rendered to members and any financial disclosures required to assess the provider's ability to deliver care.

Sources and Purpose of Data

Provider data is collected from multiple sources, including but not limited to:

- Credentialing and recredentialing documentation
- Provider onboarding forms
- Practice rosters and change notifications

- Annual or biannual provider data attestations
- Claims and encounter data submissions

CenCal Health uses this data to:

- Fulfill federal and state reporting obligations to the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and Centers for Medicare & Medicaid Services (CMS).
- Maintain accurate provider directories in compliance with SB 137.
- Ensure timely claims payment.
- Support member access, care coordination, prior authorization processes, and quality improvement initiatives.

Data Submission Standards

Providers must submit data in accordance with CenCal Health protocols and standards for:

- Timeliness: Following any change, data must be submitted promptly. For more information on what must be submitted, see Notification of Changes section below.
- Consistency: When submitting multiple changes, provider must ensure consistency across all documentation.
- Accuracy: Providers must correct errors, omissions, or outdated information prior to submission. If incorrect data is submitted, it must be corrected upon identification, reported, and corrected.

Failure to comply with data submission standards may result in claim denials, prior authorization issues, removal from provider directories, or corrective action.

Required Reports and Disclosures

Providers must supply reports or documentation upon request, as needed to meet legal and contractual obligations. This may include:

- Service utilization and encounter reporting.
- Financial disclosures related to the delivery of Covered Services.
- Data necessary to demonstrate compliance with contractual or regulatory requirements, which may include requests for medical records.

Attestation Requirements

To ensure the accuracy of the directory and operational data:

- Group practices must attest to their provider roster at least once every 12 months.
- Solo practitioners must attest twice per calendar year.

Providers may use CenCal Health's standardized Provider Roster Template for this purpose, available at:
www.cencalhealth.org/providers/provider-profile-and-practice-changes

CenCal Health will also accept provider-generated rosters if all required fields are included.

Notification of Changes
Providers must notify CenCal Health in writing within 10 business days of any changes, including:

- Provider status (e.g., departure, retirement, leave of absence)
- New or closed practice locations, or address changes
- New rendering providers have been added to a group
- Office hours, phone numbers, or contact information updates
- Licensing or hospital privilege changes
- Licensure actions, suspensions, or exclusions
- Changes to Medi-Cal or Medicare enrollment status
- Changes in Medicare opt-out status
- Change in patient acceptance (e.g., no longer accepting new Medi-Cal patients)
- Other Changes, including but not limited to:
  - TIN updates
  - Name changes

Support and Contact Information
For assistance with provider data reporting, attestations, or updates, contact:

Provider Services Data Integrity Team: Providerdata@cencalhealth.org

All data reporting, attestations, or updates can be submitted to CenCal Health's Provider Services Department at the email above, faxed to 805-681-3015, or sent via the Secure File Link at https://gateway.cencalhealth.org/form/ps.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D11: Mandated Reporting of Provider Preventable Conditions (PPCs)

Federal regulations and state law require that providers report all provider-preventable conditions (PPCs) to the California Department of Health Care Services (DHCS). This applies to all providers and facilities contracted with CenCal Health.

There are two types of PPCs:

1. Health care-acquired conditions (HCAC), which should be reported if these occur in an inpatient acute care hospital.

2. Other provider-preventable conditions (OPPC), which should be reported if these occur in any health care setting, including at long-term care facilities (LTCs).

All PPCs for any Medi-Cal members must be reported to DHCS no later than five working days after discovery of the PPC using the DHCS secure online reporting portal. This applies to all PPCs not present on admission (POA), regardless of whether Medi-Cal reimbursement is sought for treatment of the PPC.

Inpatient acute care hospitals and facilities are required to report OPPCs and HCACs for any CenCal Health member.

To report a PPC, providers must:

- Log in to the California Department of Health Care Services website to submit information for each provider-preventable condition, and;
- Send CenCal Health a copy of the PPC Report via fax to 805-681-3075. Generating this form is described within DHCS's Provider-Preventable Conditions page; the online portal allows providers to print their PPC Report after they submit the PPC Report to DHCS via the portal.

Providers must submit the form within a reasonable timeframe of discovering the event.

Even if an adverse event or a healthcare-associated infection (HAI) was already reported to the California Department of Public Health (CDPH), providers are required to also report PPCs to DHCS, as reporting requirements for PPCs are different than those for adverse events and HAIs reported to CDPH.

Please note that CenCal Health is required to monitor claims data on a monthly basis and to report all potential PPC diagnoses to DHCS. This does not release providers/facilities from their requirement to report.

For any questions regarding this federally mandated DHCS reporting, please contact the Provider Services Department at 805-562-1676. Providers may also email questions about PPCs to PPCHCAC@dhcs.ca.gov.

Claim Reporting

HCAC must utilize diagnosis codes to indicate any Corresponding Complication (CC) or comorbidity or major complication (MCC) related to the PPC. Federal legislation prohibits Medi-Cal payment for the treatment of PPC, and a payment adjustment may be applied. Please refer to the CMS.gov website for a list of required diagnosis codes and, in some cases, procedure codes that can be reported on a claim related to HCAC.

Reference Links:

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

DHCS Provider-Preventable Conditions
www.dhcs.ca.gov/individuals/Pages/PPC_Reporting.aspx

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

D12: Secure Data Sharing Methods

CenCal Health is committed to ensuring the secure, timely, and compliant exchange of member health information to support care coordination, population health management, and whole-person care. This commitment aligns with state and federal mandates, including the California Data Exchange Framework (DxF), CMS Interoperability and Patient Access Rule, and HIPAA Privacy and Security Rules.

California Data Exchange Framework (DxF)

The DxF, a central element of the CalAIM initiative launched in January 2022, enables the secure, bidirectional exchange of health and social services data among participating entities. CenCal Health participates in the DxF through the execution of a Data Sharing Agreement (DSA) as required under Health and Safety Code §130290 and described in DHCS All Plan Letter 23-013. All contracted Network Providers who have signed the DSA are expected to comply with the terms outlined below.

The DxF promotes:

- Standardized, real-time data exchange across medical, behavioral health, and social care providers.
- Whole-person care through the integration of physical health, mental health, and community-based support data.
- Improvements in the quality, safety, and efficiency of care delivery.
- Health information creation, including the use of national standards in clinical documentation, health plan records, and social services data.
- Translation, mapping, controlled vocabularies, coding, and data classification.
- Storage, maintenance, and management of health information.

This agreement for the California Human Services Data Exchange Framework, executed in accordance with Health and Safety Code section 130290, is detailed in the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-013 and applies to network providers.

Interoperability and Data Sharing Requirements

CenCal Health adheres to CMS's Interoperability and Patient Access Rule (42 CFR §§ 422.119 & 423.136). This rule mandates that CenCal Health make health data available to:

- Members via secure, third-party apps using FHIR APIs.
- Other health plans, at member request, during transitions in coverage.
- Providers and care teams, to support continuity of care and minimize gaps.

CenCal Health must meet Medicare-Medicaid coordination and data-sharing obligations required by CMS and applicable DHCS Contracts to support integrated care and benefits coordination.

HIPAA-Compliant Information Exchange

The HIPAA Privacy Rule requires the individual's written authorization for any use or disclosure of protected health information (PHI) not otherwise expressly permitted or required by the Privacy Rule.

Further, the Privacy Rule allows HIPAA authorizations to be obtained electronically from individuals, provided any electronic signature is valid under applicable law.

Key Methods of Secure Data Exchange

CenCal Health employs multiple secure technologies and protocols to support compliant data sharing, including:

- **Health Information Exchange (HIE) Networks** (e.g., DxF)
    - The HIE/QHIO is not an exchange it is a data repository.
- **Secure File Transfer Protocol (SFTP).**
- **FHIR APIs**
    - End points: Members, Plans and Providers.
- **Encrypted email and secure portals** for document exchange.
- **EDI (Electronic Data Interchange)** transactions for claims, encounters, and authorizations.

Reference Links:

CalAIM Data Sharing Authorization Guidance
www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance.pdf

How do HIPAA authorizations apply to an electronic health information exchange environment?
www.hhs.gov/hipaa/for-professionals/faq/554/how-do-hipaa-authorizations-apply-to-electronic-health-information/index.html

Department of Health Care Services All Plan Letter 23-013
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-013.pdf

Section E: Covered Benefits and Services

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E1: Covered Services Overview

This section applies to Medi-Cal:

"Covered Services" refers to those medically necessary items and services available to a member through CenCal Health's Medi-Cal program. These services include Medi-Cal covered services and optional Medi-Cal services administered by CenCal Health, as well as Medi-Cal covered services not administered by CenCal Health.

Eligibility

The providers are responsible for verifying the recipient is eligible with CenCal Health for the date of service. Eligibility can be verified via the Provider Portal at www.cencalhealth.org.

Medi-Cal Covered Services Administered by CenCal Health

CenCal Health is responsible for the provision of and access to the programs and Covered Services listed below, and as further detailed in CenCal Health's policies and procedures. Medi-Cal Covered Services administered by CenCal Health include, but are not limited to, the following:

- Physician services
- Hospital inpatient and outpatient services
- Whole Child Model (WCM) and California Children's Services (CCS)
- Emergency care services
- Health education programs
- Home healthcare
- Maternity care services
- Family planning
- Sexually transmitted disease services
- HIV testing and counseling
- Pregnancy termination and abortion services
- Nurse midwife and certified nurse practitioner services
- Lab tests and X-rays
- Prenatal care
- Immunizations
- Durable medical equipment
- Medical supplies
- Prosthetics and orthotics
- Pediatric preventive services (CenCal Health CHDP Program)
- Minor consent services
- Physician Administered Prescription drugs
- Transportation – emergency

- Transportation – non-medical and non-emergency medical transportation services
- Hospice
- Long-term care and skilled nursing care services
- Physical therapy/occupational therapy
- Vision services
- Mental health services
- Non-Specialty Mental Health Services (NSMHS) for minors
- Behavioral Health Treatment (BHT)
- Medication for Addiction Treatment (MAT)
- Palliative care
- Indian Health Services programs

Medi-Cal Covered Services not administered by CenCal Health

CenCal Health does not administer certain Medi-Cal covered services. The following identifies these covered services, as well as where to obtain more information in this Provider Manual about referrals for these services:

- Non-CenCal Health members with California Children's Services (CCS) eligibility.
- Dental services (see Section F, F1: Dental Services for Medi-Cal Members).
- Substance Use Services (see Section F, F3: County Substance Use Services).
- Local education agency services. For more information about Medi-Cal covered services, please visit the Medi-Cal website.
- Specialty mental health services (see Section F, F2: Specialty Mental Health Services).

Reference Link:

DHCS Medi-Cal Providers
www.medi-cal.ca.gov

This section applies to CenCal CareConnect:

CenCal CareConnect's covered benefits include services under Medicare, but also extra services not normally covered under Medicare. CenCal CareConnect's Summary of Benefits provides a description of all benefits covered under CenCal CareConnect, including Medicare benefits and supplemental benefits.

CenCal CareConnect covered services include, but are not limited to:

- Acupuncture
- Ambulatory surgical center services
- Ambulance services
- Chiropractic services
- Diagnostic tests, X-rays, lab, and radiology services
- Durable medical services
- Dialysis services
- Emergency services
- Hearing aids

- Hearing services
- Home health services
- Hospital outpatient services
- Hospice
- Inpatient hospital care
- Inpatient mental health services
- Medically necessary ambulance
- Medicare (Part B) and Part D prescription drugs
- Occupational, physical, or speech therapy
- Outpatient mental health services
- Outpatient rehabilitation services
- Physician services
- Podiatry services
- Preventive care
- Prosthetic and orthotic services
- Radiology services
- Rehabilitation services
- Skilled nursing facility/nursing home care
- Transportation services
- Urgent care
- Vision care

Medicare Covered Services Not Administered by CenCal CareConnect

- Inpatient Psychiatric Care beyond 190 days
- Certain dental services
- Dental managed care (DMC) member contact information can be found at: https://www.dental.dhcs.ca.gov/Contact_Us/Medi-Cal_Dental_Member_Contact_Information/MediCalDentalMemberContactInformation
- Certain hospice care services covered outside of CenCal CareConnect
- Psychosocial rehabilitation
- Rest home room and board

This section applies to the following CenCal Health programs:

Medi-Cal

E2: Limited Services

Limited Services are restricted benefits for CenCal Health Medi-Cal members. Limited Services for adult members include, but are not limited to, acupuncture, audiology, and chiropractic services, which are subject to a maximum of two (2) services per month or a combination of two (2) services per month.

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

Physical therapy services are allowed up to a maximum of eighteen (18) services per year without an authorization. Additional services may be provided based upon medical necessity through the TAR process. For further instructions on TARs, please refer to Authorization Section H of the Provider Manual.

Occupational therapy and speech therapy services that may be rendered by an out-of-network provider, including Medi-Cal non-benefit procedures, or services delivered to members enrolled in the California Children's Services (CCS) program, or members who have a potential CCS-eligible diagnosis, will be based upon medical necessity.

Eligibility

- The provider will be responsible for verifying that the recipient is eligible with CenCal Health for the date of service. Eligibility can be verified in CenCal Health's Provider Portal at www.cencalhealth.org, or providers can call CenCal Health's Member Services Department at 877-814-1861.

Billing for Covered Services

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

Authorizations:

"Medi-Reservation pertains to a method of limiting the Medi-Services (or "Limited Services") allowed under the Medi-Cal program, whereby a member is entitled to two visits or services per month. Please refer to Section H of the Provider Manual.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E2.1: Acupuncture Services

CenCal Health members may access acupuncture services (limited services – two per month total) to prevent, modify, or alleviate the perception of severe, persistent, or chronic pain resulting from a generally recognized medical condition.

Types of Services Provided

The following acupuncture services are Covered Benefits for CenCal Health members:

- Services rendered by a physician, podiatrist, or certified acupuncturist who is enrolled in the Medi-Cal program, eligible to provide Medi-Cal and Medicare services, and contracted with CenCal Health as a provider.
- Limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
- Acupuncture used with or without electric stimulation of the needles.
- Used to treat a condition also covered by other modalities.
- Subject to two services per month (total).

Authorizations

Acupuncture services are subject to a limit of two services per month. Additional services may be provided based upon medical necessity through the TAR/Prior Authorization process. For further instructions on TAR/Prior Authorization Requests, please refer to Authorization Section H3 of the Provider Manual.

A provider shall be reimbursed by CenCal Health for Covered Services rendered to members as indicated in Exhibit A of the provider's Allied Amendment Agreement.

E2.2: Audiology Services

This section applies to Medi-Cal:

CenCal Health members may access audiological services to determine hearing loss and evaluate the need for a hearing aid. Access to hearing aids includes both the instrument and the fitting of the hearing aid, education, adjustments, and repairs, as indicated below.

Definitions

Audiologist: A person who performs procedures of measurement, appraisal, identification, and counseling related to hearing and disorders of hearing; provides rehabilitation services for the modification of communicative disorders resulting from hearing loss affecting speech, language, and auditory behavior; and recommends and evaluates hearing aids. An audiologist shall be licensed by the Speech Pathology and Audiology Examining Committee of the State Board of Medical Quality Assurance or similarly licensed by a comparable agency in the state in which they practice.

Audiological Services: Services for the measurement, appraisal, identification, and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language, and auditory behavior, and the recommendation and evaluation of hearing aids.

Hearing Aid: Any aid prescribed for the purpose of aiding or compensating for impaired human hearing loss.

Type of Services

Audiological services offered by providers acting within the scope of their practice as authorized by California law are covered by CenCal Health.

Audiological Services	Audiological evaluation to measure the extent of hearing loss and hearing aid evaluation to determine the most appropriate make and model of hearing aid.
Hearing Aid Services	Hearing aids, monaural or binaural, including ear mold(s), hearing aid instrument, the initial battery, cords, and other ancillary equipment. Includes visits for fitting, counseling, adjustments, and repairs. Surgically implanted FDA-approved hearing devices, including implantable cochlear devices for bilateral, profoundly hearing-impaired individuals who do not benefit from conventional amplification (hearing aids).
Non-Covered Charges	Batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase. Charges for a hearing aid, which exceeds specifications, prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of hearing aids after the covered 1-year warranty period, and replacement of a hearing aid more than once in any period of 36 months.

Covered Audiology and Hearing Aids Benefits for CenCal Health Members

Audiological services for CenCal Health members are considered Limited Services. One initial or first visit may be allowed for each member in a six-month period for each provider, and it is included in the two services per month limitation that applies to all limited-service providers. This initial visit, which does not require prior authorization from the Primary Care Provider (PCP) or attending physician, should be billed with HCPCS Code X4502.

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

Authorizations

Referrals and prior authorizations are not required for a member to access audiology services. A Medi-Reservation must be made by the audiologist for each visit provided. Authorization will not be granted to extend audiology services beyond the services reserved through a Medi-Reservation. Services may be reserved by completing and submitting the Medi-Reservation Form found on CenCal Health's website: www.cencalhealth.org. A confirmation number will be given once the service is reserved. For more information on Medi-Reservations, please refer to Section H, H5 of the Provider Manual.

Documentation of Services
The audiologist shall document services by completing a claim form and submitting the form to CenCal Health. The audiologist shall also provide documentation to the member's PCP.

This section applies to CenCal CareConnect:
CenCal CareConnect covers audiological services, including evaluations to measure the extent of hearing loss and hearing aid assessments. These services specifically refer to hearing and balance evaluations provided by a qualified audiologist who is legally authorized under state law (or the applicable state regulatory mechanism) to perform such services and would be covered in the same manner as if furnished by a physician.

An audiologist may furnish diagnostic audiology tests for a member once per member per 12-month period without an order from the physician or non-physician practitioner treating the member. Such diagnostic audiology tests can be for non-acute hearing conditions but may not include audiology services that are related to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.

Hearing aid devices are covered at a limited dollar amount per year. Hearing aid devices covered: Monaural, binaural, and contralateral routing devices. Coverage for hearing aid devices is offered as a supplemental benefit under CenCal CareConnect.

Prior authorization is not required for audiology services/hearing tests and evaluations.

E2.3: Chiropractic Services

This section applies to Medi-Cal:

Type of Services Provided
Services provided by chiropractor providers are covered by CenCal Health. A member may access chiropractic services for treatment of the spine and neck by means of manipulation.

Covered Chiropractor Services
Chiropractic services are a restricted benefit for CenCal Health members. A total of two (2) visits per month are allowed. The following chiropractic services are covered benefits for members and services meeting the criteria listed below:

- Services rendered by a chiropractor who is enrolled in the Medi-Cal program, eligible to provide Medi-Cal services, and contracted with CenCal Health as a provider. If there is not a contracted provider available, CenCal Health will authorize services to a non-contracted provider at no additional cost to the member.
- Services limited to the treatment of the spine rendered by a licensed chiropractor.

- Individuals eligible for Medi-Cal for Kids & Teens.
- Pregnant individuals for pregnancy-related services and services for other conditions that might complicate the pregnancy.
- Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the nursing facility to be covered. Members can be identified by an Aid Code of 13, 23, 53, or 63 when checking eligibility.
- Rendered by a Federally Qualified Health Center (FQHC).

Authorizations

Referrals and prior authorizations are not required for a member to access chiropractic services unless the request for chiropractic care exceeds the two-visit per month limit. A Medi-Reservation must be made by the chiropractor for each visit provided. Services may be reserved by completing and submitting the Medi-Reservation Form found on CenCal Health's website: www.cencalhealth.org. A confirmation number will be given once the service is reserved. For more information on Medi-Reservations, please refer to Section H, H5 of the Provider Manual.

Should a chiropractor feel that X-rays are necessary, they should contact the member's PCP or attending physician and discuss the need for these diagnostic services. The PCP or attending physician may authorize the diagnostic services to a contracted radiology or X-ray provider.

References:

Medi-Cal Provider Manual

California Code of Regulations [CCR], Title 22, Section 51308)

This section applies to CenCal CareConnect:

CenCal CareConnect, in accordance with Medicare Benefit Policy, Chapter 15, Section 30.5, limits coverage of chiropractic services to help correct a subluxation (when one or more of the bones of the spine move out of position) using manipulation of the spine.

Qualified Provider:

A chiropractor must be licensed or legally authorized to furnish chiropractic services by the state or jurisdiction in which the services are furnished. In addition, a licensed chiropractor must meet the uniform minimum standards to be considered a physician for Medicare coverage as defined in the Medicare Benefit Policy Manual, Chapter 15, Section 30.5. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation, provided such treatment is legal in the state where performed. All other services furnished or ordered by chiropractors are not covered.

If a chiropractor orders, takes, or interprets an X-ray or other diagnostic procedure to demonstrate a subluxation of the spine, the X-ray can be used for documentation.

However, there is no coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor.

In addition, in performing manual manipulation of the spine, some chiropractors use manual devices that are hand-held, with the device's thrust of the force controlled manually. While such manual manipulation may be covered, there is no separate payment permitted for use of this device.

Maintenance Therapy:
Chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

Prior Authorization: Prior Authorization may apply to these services.

Reference:
Medicare Benefit Policy Manual, Chapter 15, Section 30.5

E2.4: Hearing Aids Services

This section applies to Medi-Cal:

Services provided by hearing aid providers are covered by the CenCal Health members and according to the California Code of Regulations (22 CCR 51319) for Hearing Aids.

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

Covered Hearing Aid Services
CenCal Health covers hearing aids when supplied by a hearing aid dispenser with a prescription from an otolaryngologist or the Primary Care Provider. An audiological evaluation, including a hearing aid evaluation performed by, or under the supervision of, the above prescribing physician or by a licensed audiologist, is required.

The following procedures are Covered Benefits as indicated below:

- A hearing test to measure the extent of hearing loss.
- A hearing aid evaluation to determine the most appropriate make and model of hearing aid.
- Hearing aids, monaural or binaural, including ear mold(s), hearing aid instruments, the initial battery, cords, and other ancillary equipment.

Non-Covered Charges

- Batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase. Charges for a hearing aid that exceeds the specifications prescribed for correction of hearing loss.
- Replacement parts for hearing aids or repair of hearing aid after the covered 1-year warranty period.
- Replacement of a hearing aid more than once in any period of 36 months.

Authorizations

Referrals and prior authorizations are not required for a member to access hearing aid services. A Medi-Reservation must be made by the hearing aid supplier for each visit provided. Authorization will not be granted to extend hearing aid services beyond the services reserved through a Medi-Reservation. Services may be reserved by completing and submitting the Medi-Reservation Form found on CenCal Health's website: www.cencalhealth.org. A confirmation number will be given once the service is reserved. For more information on Medi-Reservations, please refer to Section H, H5 of the Provider Manual. (Please reference Section E13 for CCS Guidelines, as this differs for CCS members.)

This section applies to CenCal CareConnect:

CenCal CareConnect covers hearing aids when prescribed by a physician or other qualified provider. Members receive hearing aid coverage through Medi-Cal, with additional hearing aid benefits available through CenCal CareConnect, including:

- Molds, supplies, and inserts
- Repairs
- An initial set of batteries
- Six (6) visits for training, adjustments, and fitting with the same hearing aid vendor
- Trial period rental of hearing aids
- Assisted listening devices, surface-worn bone-conduction hearing devices
- Hearing aid-related audiology and post-evaluation services

CenCal CareConnect covers up to $650 allowance for hearing aids and accessories every calendar year, beyond the Medi-Cal coverage. Maximum of two (2) devices per year.

Authorization:

Authorization: Prior authorizations and referrals are not required for hearing aid services.

E2.5: Home Health Services

CenCal Health members may access health services provided at their home, including skilled medical services, if they are homebound.

Covered Services

The following home health services are Covered Benefits for CenCal Health members:

- Diagnostic and treatment services that can reasonably be provided within the home.
- Nursing care provided by a registered or licensed vocational nurse or a certified home health aide who is working in conjunction with a registered or licensed vocational nurse. Services can include, but are not limited to, patient and caregiver education, intravenous, or nutrition therapy.
- Rehabilitation and/or physical, occupational, or speech therapy, as determined by the physician to be medically necessary.
- Medical supplies, if they are given by approved providers and are in accordance with the member's written treatment plan.
- The use of medical appliances, if it is in accordance with the member's written treatment plan.

Authorizations

Prior authorization is required for services beyond case evaluation. Certain services performed in conjunction with the initial case evaluation are exempt from this requirement. The authorization request must include a written treatment plan attached to a Treatment Authorization Request form (TAR/Prior Authorization referral with the requested CPT codes. Please refer to the Authorization Section H, H4 for further instructions.

E2.6: Hospice Services

CenCal Health members may access hospice services so that they may receive care and assistance with the physical, emotional, social, and spiritual discomfort associated with the last phases of life due to the existence of a terminal disease.

Covered Services

CenCal Health covers the following hospice services as Covered Benefits Services connected to the medical management of the pain and symptoms associated with a terminal illness and its related conditions.

- Skilled nursing services, certified health aide services, and homemaker services under the supervision of a qualified registered nurse.
- Physician services.
- Physical, occupational, and speech pathology services for the purpose of symptom control or to enable members to maintain activities of daily living and basic functional skills.
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility.
- Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the management of terminal illness and related conditions.
- Medical social services.
- Counseling (bereavement, grief, dietary, spiritual).

- Continuous nursing during crises.
- Inpatient respite care (≤ 5 days).

A separate payment will not be made for the following hospice services:

- Hospital, nursing facility (Level A & B), and home health agency care.
- Medical equipment and supplies, and pharmaceuticals.
- Medical transportation.

Authorization

This section applies to Medi-Cal:

Providers must obtain a pre-authorization for inpatient hospice care via an approved Treatment Authorization Request (TAR) for CenCal Health members. Hospice services for routine home care, continuous home care, respite care, and hospice physician services do not require prior authorization.

This section applies to CenCal CareConnect:

For CenCal CareConnect members, original Medicare will cover any Part A or B services related to a terminal illness. The hospice provider will bill Medicare for these services. CenCal Health covers services not covered under Medicare Part A or B. Services are covered whether or not they are related to the terminal prognosis. There is no cost to the members for hospice services. For Part D eligible drugs dispensed to members that are not included in Part A/B, a copay may still apply. No authorization is required for this service.

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

**Pediatric Services/CCS is excluded from CenCal CareConnect.

E2.7: Incontinence Supplies

CenCal Health follows the state of California Medi-Cal and CMS guidelines for incontinence supplies in most cases. Please review those guidelines in the Incontinence Medical Supplies: An Overview in the Durable Medical Equipment and Medical Supplies (DME) section of the Medi-Cal Provider Manual as published by the California Department of Health Care Services (DHCS): www.medi-cal.ca.gov. Unless otherwise noted below, providers of incontinence supplies are subject to Medi-Cal guidelines.

For CenCal CareConnect, see additional information in the Medicare Benefit Policy Manual, Chapter 15.

The guidelines below provide CenCal Health's criteria for providing incontinence supplies and submitting claim submissions. They are meant to assist you in ensuring a timely outcome for payment of incontinence supplies. If you have any questions regarding the information described in these Protocols, please refer to the Contact section at the end of this document.

Prescription

A prescription is required for any provision of incontinence supplies for CenCal Health members. Providers of incontinence supplies are required to use the Incontinence Supplies Prescription Form as published by the California Department of Health Care Services (DHCS) and provided in the Medi-Cal Provider Manual: www.medi-cal.ca.gov.

- The prescription is only valid for a six-month period, and it must be renewed every six months for updated medical justification.
- The member's physician (Primary Care Provider or attending physician) must write individual prescriptions prior to the delivery of service, ordering only those supplies necessary for the care of that member.
- The physician's medical record must show each prescription with the anticipated rate of use for the specific item, as well as the specific diagnosis and the type of incontinence for which the supplies were prescribed.
- A copy of the current prescription must be retained in the member's medical chart.

Limitations

Incontinence supplies have both a quantity per period threshold and a monthly dollar limit threshold under Medi-Cal guidelines. CenCal Health waives the quantity limitations for some incontinence supplies and instead institutes a maximum monthly dollar threshold. Incontinence supplies are limited to $165, including sales tax and markup, per member, per calendar month. Still, if supplies over the $165 limit are medically necessary, a Treatment Authorization Request (TAR)/Prior Authorization Request is required and can be submitted to override the limit.

Affected supplies under the cost limitation include disposable briefs (diapers), protective underwear (pull-on products), underpads, belted undergarments, shields, liners, pads, and reusable underwear. The procedure codes listed in the Medi-Cal Manual, Durable Medical Equipment (DME) and Medical Supplies, are under the monthly dollar threshold of $200 and have their quantity limitation waived up to the $200 threshold.

Incontinence Creams & Washes

Continued Services:

- Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy. Please include modifier TH on your claim form. This modifier can be used for up to sixty (60) days after delivery.
- Crossover claims for members are also covered by Medicare. If the service is unable to be billed to Medicare, i.e., Medicare non-covered items, then the service will not be covered by CenCal Health and CenCal CareConnect.

In addition, the following members are covered:

- Members 20 years old and under.
- Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the

nursing facility to be covered. Members are identified by an Aid Code of 13, 23, 53, or 63 in the Eligibility Screen.

Reference Link:

Medi-Cal Durable Medical Equipment (DME) and Medical Supplies
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=durable-medical-equipment-and-medical-supplies

E2.8: Laboratory Services

Covered Services

Services provided by laboratory providers, acting within the scope of their practice as authorized by California law, are covered by CenCal Health and include the biological, microbiological, serological, chemical, immunohematology, hematological, biophysical, cytological, pathological, or other types of examination of materials derived from the human body, for purposes of diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

Covered Laboratory Benefits

- Maternity care: Laboratory testing, including some genetic and alpha-fetoprotein testing.
- Diagnostic services in outpatient hospitals and other outpatient facilities.
- Laboratory services in inpatient hospital settings.
- Diabetes management and treatment, including outpatient services and laboratory testing.
- Including at a minimum: Cholesterol, triglycerides, microalbuminuria, HD/LDL, and Hemoglobin A-1C (Glycohemoglobin).
- Testing to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications.

Access

A member may access laboratory services in the following settings: hospital/inpatient in both acute and rehabilitation hospitals, outpatient hospital and other outpatient facilities, for pregnancy and maternity care, when receiving services under the diabetes management and treatment benefit, and as directed by physicians and other health professionals.

Authorizations

Prior authorization may be required for certain services. To verify authorization requirements, please refer to Section H3.

Specific Authorization of Laboratory Services

Laboratory services that are provided in a setting in which required authorization would be obtained by the facility, i.e., an inpatient hospital setting, would not require additional authorization.

E2.9: Lactation Services

Covered Services

One of the benefits offered to eligible women under the Medi-Cal and CenCal CareConnect programs is the services of an International Board-Certified Lactation Consultant (IBCLC).

Lactation services are available for mothers in need of breastfeeding information. The focus of these lactation consultations is to assess the woman's ability to breastfeed and resolve issues they may have related to breastfeeding. CenCal Health has authorized IBCLCs to provide up to a two-hour consultation in the office, home, or hospital without prior authorization.

Authorizations

The member may receive lactation services for a maximum of 120 minutes without prior authorization. Services may be provided in the office, hospital, or in the member's home. Additional services require prior authorization.

E2.10: Nursing Facility

Covered Services

CenCal Health covers services provided in a skilled nursing facility or long-term care facility. The provider shall adhere to the rules and regulations pursuant to the California Health Facilities Licensure Act, and to the rules and regulations of the Medi-Cal and Medicare CareConnect programs. Additionally, the nursing facilities will comply with the Welfare and Institution Code Section 9390.5 in regards to the PS/PASARR Level 1 screening or evaluation, either prior to admission or on the first day for which authorization is requested.

Nursing facility represents and warrants that it is currently and for the duration of this Agreement shall remain certified under Title 18 of the Federal Social Security Act.

For CenCal Health members, nursing facilities that serve members for a primary psychiatric disorder are not covered by CenCal Health, but by the local County Mental Health Plan. Nursing facility services are covered directly by CenCal CareConnect.

Definitions

Day or Days: Calendar days unless otherwise noted.

Facility Services: Includes, but is not limited to, the following services when ordered by a member's responsible physician or other qualified health practitioner and rendered to members in accordance with the W&I Codes, applicable sections of 22 CCR for Skilled

Nursing Facilities and intermediate care facilities, subject to any exclusions, limitations, exceptions, and conditions as may be set forth in the Agreement.

- Room and board.
- Nursing and related care services, including Skilled Level of Care therapy needs, per MD direction.
- Commonly used items of equipment, supplies, and services used for the medical and nursing benefit of members in applicable provisions of the state Medi-Cal program referenced in 22 CCR.
- Administrative services required for providing inpatient services.

Nursing Facility: A facility that is licensed as either a Skilled Nursing Facility or an Intermediate Care Facility.

Skilled Nursing Facility: Any institution, place, building, or agency that is licensed as a Skilled Nursing Facility by DHCS or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR § 51215 (except that the distinct part of a hospital does not need to be licensed as a Skilled Nursing Facility) and has been certified by DHCS for participation as a Skilled Nursing Facility in the Medi-Cal program. The term "Skilled Nursing Facility" shall include the terms "skilled nursing home," "convalescent hospital," "nursing home," or "Nursing Facility."

Skilled Nursing Facility Level of Care: Level of care provided by a Skilled Nursing Facility meets the standards for participation as a provider under the Medi-Cal program as set forth in 22 CCR § 51215.

Services

Coverage shall be provided in accordance with the standards set forth in 22 CCR § 51335 and any or all attachments to Exhibit A and in the Member's Evidence of Coverage (EOC). Services CenCal Health covers include, but are not limited to:

- Semi-private room (or a private room if medically necessary)
- Meals, including special diets
- Nursing services
- Physical, occupational therapy, and speech therapy
- Respiratory therapy
- Medications provided as part of plan of care
- Blood, including storage and administration
- Medical and Surgical supplies
- Lab tests, X-rays, and other radiology services in the nursing facility
- Use of appliances such as wheelchairs
- Physician services
- Durable medical equipment
- Podiatry services
- Chiropractic services

Access
Nursing Facility shall provide Medi-Cal and Medicare Facility services to members, subject to the availability of appropriate skilled nursing care services and/or intermediate care services. Nursing Facility shall additionally adhere to the provisions of the Medi-Cal Long Term Care Manual (https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=long-term-care) and CMS Manuals (www.cms.gov/medicare/regulations-guidance/manuals).

Authorizations – Please refer to Section H3 of the Provider Manual.

E2.11: Nutrition Educators

Covered Services
Nutrition educators providing medical nutrition therapy (MNT) services are covered by CenCal Health when conducted by a Registered Dietitian (RD) working as or with a contracted provider. The following services are covered under the CenCal Health nutrition benefit:

- Outpatient medical nutrition therapy necessary to enable members requiring diabetes management to understand diabetes diet and nutrition, blood sugar monitoring, and medication therapy as prescribed by a provider.
- Outpatient medical nutritional therapy and counseling to members diagnosed with an eating disorder (i.e., anorexia, bulimia) to assist in the normalization of eating patterns and nutritional status, and assist with medical monitoring in collaboration with the rest of the treatment team.
    - Nutritional services for CenCal Health Medi-Cal members with an eating disorder, irrespective of whether the member is receiving outpatient mental health services through CenCal Health or County Mental Health.
    - CenCal CareConnect members with eating disorders are covered for nutritional services when deemed medically necessary.
- Nutritional counseling as a health education benefit for multiple medical conditions, including but not limited to morbid obesity, uncontrolled hypertension, hyperlipidemia, and renal or cardiovascular disease, when conducted by contracted nutrition educators.

For CenCal Health Medi-Cal Members: Under the benefit, members are entitled to an initial assessment not to exceed four hours per year, a re-assessment and intervention not to exceed two hours per month, and group sessions not to exceed eight hours per nine-month period. **Reassessments and additional services beyond these benefit limitations require prior authorization** (these limits do not apply to children under 21 due to EPSDT regulations). Members under the age of 21 do not have treatment limits apart from medical necessity criteria.

For CenCal CareConnect members with diabetes or chronic kidney disease without dialysis and post-kidney transplant (within 36 months)

- Members are entitled to three hours of 1:1 counseling during the first year of medical nutrition therapy services. In addition, two hours of 1:1 counseling annually.

- Providers may request more education if the member's condition changes.

If a hospital provides nutritional education to members on an inpatient basis at the hospital, such educational efforts should be noted in the member's chart; however, no additional payment for these services outside of the agreed upon hospital rates will be paid to the hospital.

Reference:
42 CFR 410.48 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, section 310.

E2.12: Optician Services

Covered Services
A member may access optician services when the member requires a prescription to be filled for prescription lenses and related products, as well as the fitting and adjusting of such lenses and spectacle frames, and when the service is a Covered Service under CenCal Health.

The types of services provided by dispensing opticians, acting within the scope of their practice as authorized by California law, are covered for CenCal Health Medi-Cal, and include filling prescriptions of physicians for prescription lenses and related products, fitting and adjusting such lenses and spectacle frames. A dispensing optician is also authorized to act on the advice, direction, and responsibility of a physician or optometrist in connection with the fitting of a contact lens or contact lenses. Covered Services include:

- Eyeglasses, when necessary and prescribed. (Every two years.)
- Contact lenses, when medically necessary and prescribed. (Every two years instead of glasses.)
- Visits for fitting glasses and contact lenses.

E2.13: Optometry Services

Covered Services
Optometry and optician services for CenCal Health members include an eye examination and dispensing eyeglasses, when necessary, every two years. A referral from the member's PCP is not necessary.

For CenCal CareConnect members, eye exams are covered annually. Members are eligible for one pair of eyeglasses with standard frames (or one set of contact lenses) after each cataract surgery that implants an intraocular lens.

Authorizations
Prior authorization may be required for certain services. Please refer to Section H3 for authorization guidelines.

Additionally, a member may qualify for supplemental benefits, described further in the Supplemental Benefits section of this Manual.

E2.14: Vision Services

Covered Services
One routine eye exam with refraction every 12 months, with a second eye exam with refraction when medically necessary.

Eye appliances, when prescribed by a physician or optometrist, include prescription eyeglasses, eyeglass frames (frames, standard and deluxe), contact lenses (when medically necessary), low vision aids (excluding electronic devices), and prosthetic eyes.

Members are eligible for eyeglasses every two years (frames and lenses) or contact lenses.

Authorization
Please refer to Section H3. Provider shall follow the guidelines set forth in the EDS Medi-Cal Provider Manual at Medi-Cal: Part 2 – Vision Care/CenCal CareConnect Provider Manual.

E2.15: Physical Therapy Services

A member may access physical therapy services (PT) when treatment is prescribed by a physician to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psychosocial disabilities, physical illness, or advanced age.

Type of Services Provided
Services provided by Physical Therapy providers are covered for CenCal Health members. Services include treatment prescribed by a physician or podiatrist for any bodily condition by the use of physical, chemical, and other properties of heat, light, water, electricity, or sound, and by massage and active, resistive, or passive exercise. Services also include Physical Therapy evaluation, treatment planning, treatment, instruction, consultations, and application of topical medication.

Covered PT Benefits

- Physical therapy (PT) services are a covered benefit only when provided based on a written prescription from a CenCal Health physician or podiatrist, acting within the scope of their medical practice. Additionally, physicians who treated the member during a hospital stay, as well as physician specialists to whom the member was referred, may also issue a written prescription for PT services. PT services should be rendered in the provider's office or in an outpatient department of a hospital facility.
- PT services must be performed by licensed and registered therapists.

- PT services are also covered when the member is an inpatient at an acute care hospital, in a skilled nursing facility, or at home.

Note: Pediatric members may be eligible for physical therapy services through the CCS Medical Therapy Program (MTP). Please refer to www.dhcs.ca.gov/services/ccs www.dhcs.ca.gov/services/ccs for more information.

**Pediatric Services are excluded from CenCal CareConnect.

Authorizations

- Prior authorization may be required for certain services. To verify the authorization process, please refer to Section H3 of the Provider Manual. For outpatient physical therapy, prior authorization is required beyond the first 18 visits.

E2.16: Emergency Medical Transportation Services

Covered Services

CenCal Health members may access emergency medical transportation services when the member's medical or physical condition or mental health condition requires immediate medical care and precludes the usage of public transportation or driving.

Types of Services Provided

The following emergency medical transportation services are Covered Benefits for CenCal Health members:

Medical transportation to provide access to all emergency Covered Services, including:

- Medical transportation to the nearest hospital capable of meeting a member's medical needs, independent of the hospital's contract status.
- Transportation to a second facility, when the nearest facility served as the closest source of care, but the member requires a facility with a higher level of care.
- Transportation of a member on an involuntary psychiatric status according to Welfare and Institutions Code 5150 & 5585 to the nearest hospital for medical clearance and/or to a designated facility as determined by the County Mental Health Department for further evaluation and treatment.
- Ground medical transportation services must be rendered by a provider whose ground transport vehicles are licensed, operated, and equipped in accordance with applicable state and local statutes, ordinances, and regulations.
- Air medical transportation services must be rendered by a provider whose air transport vehicles are certified by the Department of Health Care Services (DHCS) and Federal Aviation Agency (FAA), have an air medical transportation provider number, and the transport meets one of the following conditions:
    - The medical condition of the member precludes the use of other forms of medical transportation.

- The member's location or the nearest hospital capable of meeting the member's medical needs is inaccessible by ground medical transportation.
- Other considerations make ground medical transportation not feasible.

Non-Covered Services

The following emergency medical transportation services are Non-Covered Benefits for CenCal Health members:

- Transportation services other than those specifically provided for in the provider's agreement and in the member's Evidence of Coverage (EOC), including but not limited to passenger cars, taxis, or other forms of public or private conveyance.
- Services outside the scope of an emergency medical transportation provider as set forth in the EDS Medi-Cal Provider Manual.
- Services outside the scope of 42 CFR 410.40 and the Medicare Benefit Policy Manual, Chapter 10.
- **CenCal Health members under the age of 21 and hospital-to-hospital transports:** Provider must submit an attachment to the claim that supports that an emergency existed. The statement must include the following:
  - The name of the person or agency that requested the service.
  - The nature of the emergency.
  - The name of the hospital the member was transported to.
  - Clinical information on the member's condition.
  - The reason emergency transportation was considered medically necessary.
  - The name of the physician who accepted responsibility for the member.**

****Pediatric Care/services are excluded from CenCal CareConnect.**

Reference:

Medicare Benefit Policy Manual, Chapter 10

E2.17: Durable Medical Equipment

Durable medical equipment (DME) providers shall determine the current eligibility of members to receive services and equipment, for meeting the elements of and documenting services as indicated below, and in order to receive payment for submitting claim forms to CenCal Health.

Type of Durable Medical Equipment (DME) Services Provided

Services provided by DME providers, acting within the scope of their practice as authorized per California law (California Code of Regulations - 22 CCR 51321), are covered for CenCal Health Medi-Cal members.

"Durable Medical Equipment" is equipment prescribed by a licensed physician to meet the medical equipment needs of the member that:

- Can withstand repeated use.

- Is used to serve a medical purpose.
- Is useful to an individual with an illness, injury, functional impairment, or congenital anomaly.
- Is appropriate for use in or out of the member's home in accordance with Medi-Cal and Medicare Services and criteria.

DME, as prescribed, includes but is not limited to the purchase or rental of equipment, such as ambulatory items, wheelchairs, oxygen and related respiratory equipment, hospital beds and accessories, bathroom safety equipment, and home monitoring equipment for diabetes, asthma, and high blood pressure management. In addition, medically necessary repairs and replacement of DME as authorized, unless necessitated by misuse or loss.

Limitations of DME

For custom-made manual wheelchairs and power-operated wheelchairs/scooters, a "wheelchair and living environment evaluation" must be performed by a person with one or more of the following certifications:

- Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified Assistive Technology Suppliers (ATS), Assistive Technology Professional (ATP), or Rehabilitation Engineering Technologists (RET).
- Registered with National Registry of Rehabilitation Technology Suppliers (NRRTS) or Rehabilitation Technology Suppliers (RTS).
- Licensed occupational or physical therapist with continuing education in rehabilitation technology.
- Documented rehabilitation equipment training through a recognized wheelchair manufacturing company.

A certified technician may be employed by the DME provider; however, CenCal Health has contracted with specific certified evaluators to perform these evaluations in the provider's area.

Non-Covered Charges of DME

- Home monitoring equipment, except for those provided under the diabetes management program, or to treat asthma and/or high blood pressure.
- DME provided by a non-participating provider, customization of living environment or motor vehicles, experimental equipment, items that duplicate the function of other equipment, and other convenience items not generally used primarily for medical care. Examples include but are not limited to exercise equipment, air conditioners or heaters, lighting devices, orthopedic mattresses, recliners, seat lift chairs, elevators, waterbeds, household items, and furniture items.

Maximum Rental

Except for life support equipment, such as ventilators, when previously paid rental charges equal the purchase price of the rented item, the item is considered to have been purchased, and no further reimbursement to the provider shall be made unless repair or maintenance of the item is separately authorized.

Authorizations
DME providers are required to obtain a referral for certain services prior to providing services in the form of a prescription (Rx) from the member's PCP. Medical Necessity forms are available at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=durable-medical-equipment-and-medical-supplies.

Additional authorization for DME products

- Prior Authorization, in the form of a **Treatment Authorization Request (TAR)/Prior Authorization Form** for CenCal Health, is required for the purchase, repair or maintenance, or cumulative rental of DME subject to the conditions, restrictions, and exceptions as specified below:
    - **Purchases** exceeding $100 (cumulative within a calendar month).
    - **Rentals** exceeding $50 (cumulative within a 15-month period).
    - **Repairs or maintenance** exceeding $250 (cumulative within a calendar month).
- Purchase, rental, or repair of **any miscellaneous item codes.** Prior Authorization is also required for the provision of oxygen when more than 500 cubic feet are provided during one calendar month.
- Purchase, rental, repair, or maintenance of unlisted devices or equipment may require authorization as set forth in CenCal Health regulations.
- Authorization shall not be granted for DME when a household item will adequately serve the member's medical needs.
- Authorization for DME shall be limited to the lowest-cost item that meets the member's medical needs.
- Authorization for customized DME for transitional inpatient care members, skilled nursing facility, or intermediate care facility inpatients may be approved if it meets applicable regulatory provisions.

E2.18: Medical Supplies

For CenCal Health members, CenCal Health follows the state of California Medi-Cal guidelines for medical supplies. Please review those guidelines in the Durable Medical Equipment and Medical Supplies (DME) section of the Medi-Cal Provider Manual as published by the California Department of Health Care Services (DHCS), www.medi-cal.ca.gov. CenCal Health recommends that you contact contracted in-network DME providers first, and if the contracted provider is unable to provide the service, CenCal Health will review services from non-contracted providers.

For CenCal CareConnect members, CenCal Health follows the 42 CFR 410.36 and the Medicare benefit Policy Manual, Pub 100-2, Chapter 15, sections 100, 120-140 for medical supplies. If providing incontinence supplies, please refer to the Protocols for Incontinence Supplies in Section E, E2.7.

Prescription

A prescription is required for any provision of medical supplies for CenCal Health members. The prescription should be kept on file in the member's medical chart and is subject to audit by CenCal Health.

- The prescription is only valid for a six-month period, and it must be renewed every six months for updated medical justification.
- The member's physician (Primary Care Provider or attending physician) must write individual prescriptions prior to the delivery of service, ordering only those supplies necessary for the care of that member.
- The physician's medical record must show each prescription with the anticipated rate of use for the item requested.
- A copy of the current prescription must accompany all authorization requests.

Limitations

Medical supplies have a quantity per period threshold. Please refer to the Medi-Cal Manual (DHCS Medi-Cal Provider Manual), to determine the quantity allowed per timeframe.

Exceeding the quantity threshold as set forth in the Medi-Cal Manual or Medicare Benefit Policy Manual, Chapter 14. CenCal Health requires approval through a Treatment Authorization Request (TAR)/Prior Authorization Request for CenCal Health members.

Authorization (TAR) Submission/Prior Authorization Request Form

If exceeding the monthly quantity allowance, please complete an authorization. TARs Prior authorization requests may be completed by submitting electronically through the Provider Portal using the eRAF or eTAR/ Prior Authorization feature located on the CenCal Health website: www.cencalhealth.org. To request a username and password to submit web authorizations, please contact the Webmaster at webmaster@cencalhealth.org.

The maximum timeframe for a medical supply authorization is six months. All TARs Prior Authorization requests require documentation of medical necessity as defined below:

- Request only those items that will exceed the quantity threshold.
- From and through dates are not to exceed a six month timeframe.
- The primary ICD-10-CM code should be entered in the diagnosis field.
- For requests over the quantity limitations, please provide, in addition to the prescription, written medical justification explaining why the member needs supplies in excess of the thresholds set by Medi-Cal and/or CMS. This description should be in a narrative format. The provider should inform the ordering physician of quantity limitations so that medical justification can properly address the specific condition of the member.
- Enter Units of Service and Quantity fields as indicated below.

Units vs. Quantity

The "Units of Service" field on a TAR/Prior Authorization Request represents the number of months for which the item is being requested, not to exceed six months. The

"Quantity" field on a TAR/Prior Authorization Request represents the number of items being provided each month. Please do not calculate the total items being requested on the TAR for the entire timeframe; that calculation will be handled internally upon the processing the authorization.

- Please ensure that all supporting documentation and medical records are submitted through CenCal Health's Provider Portal. Paper authorization forms should be faxed with supporting documentation.
- If there is a delay in providing the required documentation, please notify the Health Services Department at 805-562-1082 or directly to the plan staff member requesting the additional documentation needed to process the authorization.
- Email is the most effective means of communication for authorizations. If you are not already receiving email notifications for authorization submission or need to update your email address, please contact the Provider Services Department at 805-562-1676.

Reference:

Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, Section 140 and Medicare Claims Processing Manual, Chapter 20

Reference Link:

DHCS Medi-Cal Manual
www.dhcs.ca.gov/formsandpubs/publications/Pages/Medi-CalProviderManuals.aspx

E2.19: Occupational Therapy

CenCal Health covers occupational therapy services when ordered on the written prescription of a physician, dentist, or podiatrist and rendered by a CenCal provider. In the event that a contracted provider is not available, authorization may be issued to a non-contracted provider at no additional cost to the member.

Occupational therapy is a medically prescribed treatment focused on improving or restoring function that may be lost or reduced by illness or injury, to improve the individual's ability to perform tasks required for independent functioning.

Prescription Requirements

Prescriptions must be realistically related to activities of daily living, such as nutrition, elimination, dressing, and locomotion, in light of the patient's functional limitations. The specific goals of training or the devices prescribed must be indicated.
The following must be present on the prescription form:

- Signature of the prescribing practitioner.
- Name, address, and telephone number of the prescribing practitioner.
- Date of prescription.
- Medical condition necessitating the service(s) (diagnosis).
- A supplemental summary of the medical condition or functional limitations must be attached to the prescription.

- Specific services (for example, evaluation, treatments, modalities) prescribed.
- Frequency of services.
- Duration of medical necessity of services. Specific dates and the length of treatment should be identified, if possible. Duration of therapy should be set by the prescriber; however, prescriptions are limited to six months.
- Anticipated medical outcome as a result of the therapy (therapeutic goals).
- Date of progress review (when applicable).
- Member's age.
- Functional limitations.
- Mental status and ability to comprehend.
- Related medical conditions.
- Delay in achievement of developmental milestones in a child or impairment of normal achievement in an adult.

Eligibility
Occupational therapy providers must confirm that the member presenting in their office is eligible for services under CenCal Health.

Note: Pediatric members may be eligible for occupational therapy services through the CCS Medical Therapy Program (MTP). Please refer to www.dhcs.ca.gov/services/ccs for more information.**

**Pediatric Services are excluded from CenCal CareConnect.

Documentation of Services
The occupational therapy provider shall document services by completing a claim form and submitting the form to CenCal Health.

Authorizations
Occupational therapy providers are required to obtain a prescription from the member's physician, dentist, or podiatrist.

Prior authorization may be required for certain services. To verify the authorization process, please refer to Section H3 of the Provider Manual.

Nursing Facility Prior Authorization Requirements
Occupational therapy services rendered to NF-A or NF-B recipients require prior authorization. A TAR/Prior Authorization Request Form must be submitted for services that are not included in the per diem rate for a nursing facility.
Authorization approval is limited to services that:
- Are necessary to prevent or substantially reduce an anticipated hospital stay.
- Continue a plan of treatment initiated in the hospital.
- Are recognized as a logical component of post-hospital care.

For occupational therapy services rendered in a certified rehabilitation center or NF-A or NF-B:

- Limitation of two services per month does not apply.
- Initial and six-month evaluations do not require prior authorization. For billing instructions, refer to "Initial and Six-Month Evaluations" in this section.
- Authorization is required for any additional occupational therapy service beyond the initial and six-month evaluation.

Please refer to the H3 Request for Authorization in the Provider Manual for more information.

Billing for Covered Services

Occupational Therapy Services:

- Occupational therapy providers shall bill using the provider's valid billing number.
- The ICD-10-CM diagnosis code(s) of the member's condition must be on the claim.
- If a member's condition is related to employment, then CMS-1500 box 10a must be checked "Yes."
- The statement "initial evaluation visit" or "six-month re-evaluation visit" must be entered in the Remarks/Additional Claim Information (Box 19) of the claim when these occupational therapy services are billed. The initial evaluation document is not required as an attachment to the claim form.

Procedure Codes

Initial and six-month evaluation descriptions are listed below.

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

For CenCal CareConnect, please refer to Medicare Managed Manual Chapter 15, Section 220, Pub 100-0, the Medicare National Coverage Determination Manual for specific conditions or services.

Description
Communication board, non-electric AAC device
Evaluation - Initial 30 minutes, plus report
Case conference and report - Initial 30 minutes
Case conference and report - Each additional 15 minutes
Occupational therapy preliminary evaluation rehabilitation, Nursing Facility (NF) B, NF-A
Treatment - Initial 30 minutes
Treatment - Each additional 15 minutes

Home or long-term care facility visit - Add
Home or long-term care facility visit - Add
Unlisted service
Case consultation and report

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

E2.20: Orthotics and Prosthetics

This section applies to Medi-Cal:
Orthotic and prosthetic providers will be responsible for first determining the eligibility of members to receive services, for meeting the elements of and documenting services as indicated below, and receiving payment for submitting claim forms to CenCal Health. Orthotics and prosthetics services will be considered in accordance with the California Code of Regulations (22 CCR 51315).

Definitions
Orthotist: A person who makes and fits orthopedic braces for the support of weakened body parts or the correction of body defects.

Prosthetic and Orthotic Appliances: Those appliances prescribed by a physician, dentist, or podiatrist for the restoration of function or replacement of body parts.

Prosthetist: A person who makes and fits artificial limbs or other parts of the body.

Eligibility
Orthotic and prosthetic providers must confirm that the member presenting in their office is eligible for services under CenCal Health and is assigned to the referring PCP for the month in which the PCP is to render services. This can be accomplished by verifying eligibility through one of CenCal Health's systems. Information regarding eligibility is in the Member Services Section of this Provider Manual.

In the event the member is not eligible under the program(s) administered by CenCal Health, payment for any services provided to the member will not be the responsibility of CenCal Health.

Orthotics & Prosthetics Benefit
Orthotics and prosthetics benefits include original and replacement devices, including but not limited to the following:

- Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of their licensure.

- Medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of their license.
- Initial and subsequent prosthetic devices and installation of accessories to restore a method of speaking incident to a laryngectomy.
- Therapeutic footwear for diabetics.
- Prosthetic devices to restore and achieve symmetry incident to mastectomy.

Non-Covered Orthotics and Prosthetics Items

- Multiple pieces of equipment serving the same purpose, unless required for medical reasons.
- Items intended for comfort or convenience.
- Equipment used for experimental or research purposes.
- Non-medical devices, including home or vehicle modifications.

Documentation of Services

Orthotic and prosthetic providers shall document services by completing a claim form and submitting the form to CenCal Health. Orthotic and prosthetic providers shall also provide documentation to the member's PCP.

Authorizations

Orthotic and prosthetic providers are required to obtain a referral for certain services in the form of a **prescription (Rx)** from the member's PCP prior to providing services. Prescription (Rx) forms are available through CenCal Health or the Medi-Cal website: www.medi-cal.ca.gov.

Additional authorization for DME products

Prior Authorization, in the form of a **Treatment Authorization Request (TAR)** for CenCal Health members, is required for the following conditions:

- **Orthotics** exceeding $250 (cumulative in a 90-day period).
- **Prosthetics** exceeding $500 (cumulative in a 90-day period).

Billing for Covered Services

Orthotic and prosthetic providers bill CenCal Health, using the provider's Medi-Cal provider number for CenCal Health members for the orthotic and prosthetic services they have provided to the eligible member. In the event the member has other coverage or third-party liability is involved, the DME provider shall follow the terms and conditions of their agreement with CenCal Health, or as indicated in "Other Health Coverage" in the Claims Section of this Provider Manual.

Copayments

No copayments for orthotics and prosthetics are required for CenCal Health members.

Reimbursement for Orthotic and Prosthetic Covered Services

Provider shall be reimbursed by CenCal Health for Covered Services rendered to members as indicated in Exhibit A of Provider's Allied Agreement.

This section applies to CenCal CareConnect:
Orthotic and prosthetic providers will be responsible for first determining the eligibility of members to receive services, for meeting the elements of and documenting services as indicated below, and receiving payment for submitting claim forms to CenCal Health. Orthotics and prosthetics services will be considered in accordance with the CMS regulations and 42 CRF 410.36 and the Medicare benefit Policy Manual, Pub 100-2, Chapter 15, sections 100, 120-140.

Definitions
Orthotist: A person who makes and fits orthopedic braces for the support of weakened body parts or the correction of body defects.

Prosthetic and Orthotic Appliances: Those appliances prescribed by a physician, dentist, or podiatrist for the restoration of function or replacement of body parts.

Prosthetist: A person who makes and fits artificial limbs or other parts of the body.

Eligibility
Orthotic and prosthetic providers must confirm that the member presenting in their office is eligible for services under CenCal Health and is assigned to the referring PCP for the month in which the PCP is to render services. This can be accomplished by verifying eligibility through one of CenCal Health's systems. Information regarding eligibility is in the Member Services Section of this Provider Manual.

In the event the member is not eligible under the program(s) administered by CenCal Health, payment for any services provided to the member will not be the responsibility of CenCal Health.

Orthotics & Prosthetics Benefit
Orthotics and prosthetics benefits include original and replacement devices, including but not limited to the following:

- Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of their licensure.
- Medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of their license.
- Initial and subsequent prosthetic devices and installation of accessories to restore a method of speaking incident to a laryngectomy.
- Therapeutic footwear for diabetics.
- Prosthetic devices to restore and achieve symmetry incident to mastectomy.
- Leg, arm, back, and neck braces, artificial legs, arms, and eyes, including replacements if required because of a change in the member's physical condition.
- For Medicare to cover a member's prosthetic or orthotic, the member must go to a supplier that's enrolled in Medicare.
- Medicare Limits: Unlimited if medically necessary and reasonable.

Non-Covered Orthotics and Prosthetics Items

- Multiple pieces of equipment serving the same purpose, unless required for medical reasons.
- Items intended for comfort or convenience.
- Equipment used for experimental or research purposes.
- Non-medical devices, including home or vehicle modifications.
- Lack of medical necessity and/or documentation from providers does not support the medical need or demonstrate the device's ability to improve the member's functional capabilities.

Documentation of Services

Orthotic and prosthetic providers shall document services by completing a claim form and submitting the form to CenCal Health. Orthotic and prosthetic providers shall also provide documentation to the member's PCP.

Authorizations

Orthotic and prosthetic providers are required to obtain a prior authorization request for services prior to providing services: www.medi-cal.ca.gov/ and www.cms.gov/medicare/regulations-guidance/manuals.

Billing for Covered Services

Orthotic and prosthetic providers can bill CenCal Health for the orthotic and prosthetic services they have provided to the eligible member. In the event the member has other coverage or third-party liability is involved, the DME provider shall follow the terms and conditions of their agreement with CenCal Health, or as indicated in "Other Health Coverage" in the Claims Section of this Provider Manual. The servicing provider must be enrolled as a participating provider in the Medicare program.

Copayments

No copayments for orthotics and prosthetics are required for CenCal CareConnect members.

Reimbursement for Orthotic and Prosthetic Covered Services

Provider shall be reimbursed by CenCal Health for Covered Services rendered to members as indicated in Exhibit A of Provider's Allied Agreement.

Reference:

42 CRF 410.36 and the Medicare benefit Policy Manual, Pub 100-2, Chapter 15, sections 100, 120-140

E2.21: Speech Therapy

Type of Services Provided

CenCal Health covers speech therapy services when ordered on the written prescription of a physician or dentist and rendered by a CenCal Health provider. Speech-language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities, and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability.

Speech Therapy Benefits for Medi-Cal Members Under the Age of 21

- Under Medi-Cal for Kids & Teens, speech therapy is covered if the service is determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. To prevent duplication of services provided by the LEA or under Early Start, CenCal Health will request verification of services provided by these entities.
- The CCS program covers ST services for children under the age of 21 when determined to be medically necessary to treat a CCS-eligible medical condition.

  **Pediatric services are excluded from CenCal CareConnect.

Eligibility

Speech therapy providers must confirm that the member presenting in their office is eligible for services under CenCal Health.

Medi-Reservation

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

Authorizations

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

Prior authorization may be required for certain services. To verify the authorization process, please refer to Section H3 of the Provider Manual.

Prescription Requirements

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

- Signature of the prescribing practitioner.
- Name, address, and telephone number of the prescribing practitioner.
- Date of referral.
- Medical condition necessitating the service(s) (diagnosis).
- Supplemental summary of the medical condition or functional limitations.
- Specific services (for example, evaluation, treatments, modalities) prescribed.

- Frequency of services.
- Duration of medical necessity for services – specific dates and length of treatment should be identified if possible. Duration of therapy should be set by prescriber.
- Anticipated medical outcome because of the therapy (therapeutic goals).
- Date of progress review (when applicable).

Recipient Information

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

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

Certified Rehabilitation Centers and Nursing Facilities

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

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

Billing for Covered Services

Speech therapy services:

- Speech therapy providers shall bill using the provider's valid billing number.
- The ICD-10- diagnosis code(s), or appropriate successor code set of the member's condition, must be on the claim.
- If member's condition is related to employment, then CMS-1500 box 10a must be checked "Yes."
- If member's condition is related to an auto accident, then CMS-1500 box 10b must be checked "Yes."
- If member's condition is related to accident other than auto, then CMS-1500 box 10c must be checked "Yes."

Procedures Codes

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

For CenCal CareConnect, please refer to Medicare Managed Manual Chapter 15, Section 220, Pub 100-0, the Medicare National Coverage Determination Manual for specific conditions or services.

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

Speech Generating Devices (SGDs)

SGDs are electronic voice-producing systems that correct expressive communication disabilities that preclude effective communication. Effective communication is defined as the member's most appropriate form of communication, allowing meaningful participation in daily activities.

Prior authorization must be obtained for both the purchase and rental of an SGD. If the SGD is billed "By Report," a copy of the relevant page(s) of the manufacturer's catalog must be attached to receive reimbursement.

The rental of an SGD will only be allowed if the member's SGD is being repaired or modified, or if the member is undergoing a limited trial period to determine appropriateness and ability to use the SGD. Purchase of an SGD must be billed with modifier NU, and the rental of an SGD must be billed with modifier RR. The repair of an

SGD should be billed with the appropriate SGD HCPCS code for the part repaired, followed by modifier RP.

Authorization of the SGD

A Prior Authorization Request requires **all** the following documentation:

- Recipient Assessment
    - Medical diagnosis and significant medical history.
    - Visual, hearing, tactile, and receptive communication impairments or disabilities and their impact on the recipient's expressive communication, including speech and language skills and prognosis.
    - Current communication abilities, behaviors, and skills, and the limitations that interfere with meaningful participation in current and projected daily activities.
    - Motor status, optimal positioning, and access methods and options, if any, for integration of mobility with the SGD.
    - Current communication needs and projected communication needs within the next two years.
    - Communication environments and constraints that impact SGD selection and features.
    - Any previous treatments of communication problems, responses to treatment, and any previous use of communication devices.
- Summary of Requested SGD
    - Vocabulary requirements.
    - Representational systems.
    - Display organization and features.
    - Rate of enhancement techniques.
    - Message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory-visual output, programmability, input modes, and their appropriateness for use by the specific recipient.
    - Portability, durability, and adaptability to meet anticipated needs.
    - Identity, significant characteristics, and features.
    - Manufacturer's catalog pages, including cost (for "By Report" SGDs).
    - Any trial period when the recipient used the recommended device(s) in an appropriate home and community-based setting that demonstrated the recipient is able and willing to use the device effectively.
    - An explanation of why the requested device(s) and services are the most effective and least costly alternative available to treat the recipient's communication limitations.
    - Whether rental or purchase of the device is the most cost-effective option, vendors.
    - Warranty and maintenance provisions available for the device(s) and services.
- Treatment Plan
    - The expected amount of time the device will be needed, and the amount, duration, and scope of any related services requested to enable the recipient to effectively use the device to meet basic communication needs.
    - Short-term communication goals.

- Long-term communication goals.
- Criteria to be used to measure the recipient's progress toward meeting both short-term and long-term goals.
- Identification of the services and providers (and their expertise and experience in rendering these services).

Claim Information

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E3: Adult Preventive Services

CenCal Health and CenCal CareConnect require the provision of all preventive health services and medically necessary diagnostic and treatment services for adults in accordance with the most recent United States Preventive Services Task Force (USPSTF) grade A and B recommendations.

https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.htmlImmunizations for adult members must also be provided in accordance with the most recent immunization recommendations published by the Advisory Committee on Immunization Practices (ACIP), California Department of Public Health (CDPH), and/or American Academy of Family Physicians (AAFP).

Primary Care Providers (PCPs) and Advanced Practice Providers are expected to ensure that this core set of preventive services is available and delivered in accordance with the above listed guidelines. Copies of these guidelines are available from CenCal Health upon request. These and additional Preventive Health Guidelines can also be found on CenCal Health's website at: www.cencalhealth.org/providers/care-guidelines/preventive-health-guidelines/

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

Preventive services shall include all medically necessary diagnostic, treatment, and follow-up services, which are necessary given the findings or risk factors identified in the

Initial Health Appointment (IHA) or during visits for routine, urgent, or emergent health care situations. Follow-up services should be initiated as soon as possible, but no later than 60 calendar days following the discovery of a problem.

Preventive services shall include all medically necessary and age-appropriate screenings recommended by USPSTF and/or ACIP/CDPH/AAFP, including but not limited to:

- Immunizations.
- Screenings for hypertension, cholesterol, sexually transmitted infections (STIs), depression, tobacco cessation, substance use, and cancer screenings.
- Laboratory tests.
- Adverse Childhood Experiences (ACEs) screening.
- Cognitive health assessment (for members 65 and older as applicable per APL 26-014).

PCPs are required to provide an Initial Health Appointment (IHA) within 120 calendar days of a member's enrollment with CenCal Health, as outlined in *Section E5 – Initial Health Appointments*. PCPs are required to provide an Initial Preventive Physical Exam (IPPE) within 12 months of enrollment to all CenCal CareConnect (HMO D-SNP) members assigned to them, as outlined in *Section E5 – Initial Health Appointments*.

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

CenCal Health requires the provision of age and risk-appropriate vaccinations in accordance with the findings of the IHA or other preventive screenings. Providers shall document in the members' medical records the receipt of vaccinations and report such information to immunization registries in CenCal Health's service areas in accordance with applicable state and federal laws. Additional details regarding IHA requirements can be found in *Section E5 – Initial Health Appointments*.

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

CenCal Health understands that in certain cases, members do not come in for physical exams for reasons beyond their PCP's control. In this case, PCPs are expected to make reasonable efforts to schedule the examinations for their assigned members on a routine basis. For members whom they have never seen, PCPs are required to actively outreach to members when they first enroll to schedule the IHA or IPPE within designated time frames. See Section E5 for more information on IHA and IPPE. If a member does not receive the appropriate services as required, the PCP must

document attempts made to contact the member and the member's non-compliance.

This section applies to CenCal CareConnect:

Annual Wellness Visits (AWVs)
CenCal Health encourages Primary Care Providers (PCPs) to conduct an Annual Wellness Visit (AWV) annually for eligible D-SNP members. AWVs support preventive care, identification of health risks, management of chronic conditions, medication review, and development of individualized care plans. AWVs also provide an opportunity to assess social and functional needs, review care coordination requirements, and address gaps in preventive and chronic care services. Providers are encouraged to coordinate with the member's interdisciplinary care team, when applicable, to support comprehensive, person-centered care. AWVs support quality improvement initiatives and comprehensive assessment of member health care needs.

- Review and update medical and behavioral health conditions.
- Assess functional status and activities of daily living (ADLs).
- Review medications and potential medication-related concerns.
- Identify social determinants of health and community resource needs.
- Address preventive care and screening gaps.
- Coordinate care with specialists, care managers, and other members of the Interdisciplinary Care Team (ICT), as appropriate.
- Discuss advance care planning, when applicable.
- Ensure documentation accurately reflects current member health status.

Reference Links:

CenCal Health Preventive Health Guidelines for Adults (English/Spanish Handout)
www.cencalhealth.org/members/medi-cal/preventive-health-guidelines/

Centers for Disease Control and Prevention (CDC) Adult Immunization Schedule by Age
www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html
CenCal Health Quality of Care
www.cencalhealth.org/providers/quality-of-care/

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

All Plan Letter (APL) 26-015: Immunization Requirements
www.dhcs.ca.gov/wp-content/uploads/2026/07/APL26-015.pdf
All Plan Letter (APL) 26-014: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older
www.dhcs.ca.gov/wp-content/uploads/2026/07/APL26-014_d4abe7.pdf
https://www.dhcs.ca.gov/wp-content/uploads/2026/07/APL26-014_d4abe7.pdf
All Plan Letter (APL) 26-01: Initial Health Appointment
www.dhcs.ca.gov/wp-content/uploads/2026/05/APL26-001.pdf

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

This section applies to the following CenCal Health programs:

Medi-Cal

E4: Pediatric Preventive Services

CenCal Health promotes all preventive health services for children in accordance with the most recent American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care as published in the Bright Futures Periodicity Schedule and DHCS guidelines (APL 23-005, *Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the Age of 21*). Immunization recommendations for all pediatric members are in accordance with the most recenthttps://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html schedule approved by the Advisory Committee on Immunization Practices (ACIP), California Department of Public Health (CDPH), and/or American Academy of Family Physicians (AAFP). These and additional Preventive Health Guidelines can be found on CenCal Health's website at: www.cencalhealth.org/providers/care-guidelines/preventive-health-guidelines/

CenCal Health also updates and publishes the Preventive Health Guidelines (PHG) annually in the *Health Matters/Temas de Salud* member newsletter. CenCal Health's Member Services Department sends the PHG documents to new members and conducts outreach to encourage Preventive Medicine Evaluations for all pediatric members due for preventive healthcare visits.

Preventive services shall include all medically necessary and age-appropriate screenings recommended by the AAP and/or ACIP, including but not limited to:

- Health and developmental history, including evaluation of physical and mental health development, as well as identification of potential risks, such as lead or tuberculosis exposure and use of drugs, alcohol, or tobacco.
- A complete physical examination.
- Oral health assessment (dental screening) and referral, including fluoride varnish application in the Primary Care Provider's office.
- Health education and anticipatory guidance appropriate to age, including but not limited to counseling about nutrition and physical activity, as well as assessment and discussion of body mass index (BMI) percentile.
- Screenings appropriate to age, including but not limited to developmental screenings, as well as tests for vision, hearing, dyslipidemia, depression, and adverse childhood experiences.
- Immunizations.
- Laboratory tests, including but not limited to tests for anemia, diabetes, lead exposure, tuberculosis, and urinary tract infections.

- Any additional health care, diagnostic services, treatments, or other measures deemed necessary to correct or improve physical or mental health conditions, which must be initiated within 60 calendar days of identifying a need.

PCPs are required to perform an IHA for each newly assigned member within 120 days of assignment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule for members age 2 and younger, whichever is sooner. For more information about IHAs, refer to *Section E5: Initial Health Appointments* of the manual.

Primary Care Providers (PCPs) should bill for preventive services using standard claim forms. Preventive Medicine Evaluations for pediatric members are covered by CenCal Health. Most routine screenings performed by primary care practitioners (i.e., visual acuity screening) are included in the preventive care exam and are not separately billable. To determine whether a particular screening is separately billable, please contact your CenCal Health Claims Representative.

Reference Links:

All Plan Letter (APL) 26-015: Immunization Requirementswww.dhcs.ca.gov/wp-content/uploads/2026/07/APL26-015.pdf

All Plan Letter (APL) 23 - 005: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule
downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.htmlAAFP Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger
www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E5: Initial Health Appointment

Initial Health Appointment (Medi-Cal)
The Initial Health Appointment (IHA) is a comprehensive health assessment conducted during a Medi-Cal member's first visit(s) within a primary care setting, typically with their assigned Primary Care Provider (PCP). The IHA helps the PCP identify and address the member's acute, chronic, preventive, and overall healthcare needs.

PCPs are required to perform an IHA for newly assigned members within 120 calendar days of assignment. For Members less than 18 months of age, the IHA must be completed within 120 calendar days of assignment or within the AAP Bright Futures Periodicity Schedule for children age 2 years and younger, whichever occurs sooner.

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

- Comprehensive health history, including medical, behavioral health, family, and social history.
- Comprehensive review of systems and physical exam, including behavioral health assessment.
- Oral health assessment (dental screening), fluoride treatment, and dental referral when appropriate.
- Assessment of the need for age/gender-specific preventive screenings or services.
- Identification of risks (e.g., lead exposure; tuberculosis exposure; drug, alcohol, or tobacco use).
- Age and gender appropriate health education and anticipatory guidance.
- Diagnosis and treatment plan for any identified condition, including referrals and care coordination when appropriate.

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

- *For all adult members,* preventive screenings and services should be provided based on the United States Preventive Services Taskforce (USPSTF) Grade A & B recommendations.
    - Note: *While not all Grade A & B recommendations must be completed during the* IHAs/IPPEs, *members must receive all required screenings in a timely manner in accordance with USPSTF guidelines.*
- *For all adult members,* immunizations should be provided in accordance with the most recent schedules and recommendations published by CDPH or when the member's provider deems it to be medically necessary, as cited in APL 26-015.
- *For all members,* PCPs must arrange necessary follow-up, diagnostic, and/or treatment services for any identified risk factors or conditions as soon as possible and no later than 60 calendar days after the IHA or other visit that identified the need for follow-up.
- *For members under the age of 21,* providers must adhere to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, also referred to by the Department of Health Care Services (DHCS) as Medi-Cal For Kids& Teens, using the American Academy of Pediatrics (AAP)/Bright Futures Periodicity Schedule.
    - This includes but is not limited to conducting Adverse Childhood Experiences (ACEs) screenings (**Refer to E6: Adverse Childhood Experiences**) and performing age-specific evaluations such as developmental, vision, and lead screenings. *For pregnant or postpartum*

members, perinatal services should be provided according to the most current standards of the American College of Obstetricians and Gynecologists (ACOG).
    - A comprehensive initial prenatal visit, including an assessment of nutritional, psychosocial, and health-education needs, must be initiated immediately after enrollment or discovering that the member is pregnant and will count as the IHA if completed within 120 days of enrollment.
- *For pregnant, breastfeeding, or postpartum members, or a parent/guardian of a child under the age of 5*, a referral to the Women, Infants, and Children Program (WIC) must be completed as required by Title 42 CFR 431.635(c).

IHA Exceptions

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

Documentation must demonstrate that all required IHA components and applicable age- and condition-specific screenings, preventive services, risk assessments, and follow-up needs have been completed, addressed, or documented in accordance with applicable contractual and regulatory requirements.

Initial Preventive Physical Exam (CenCal CareConnect)

The Initial Preventive Physical Examination (IPPE), commonly referred to as the "Welcome to Medicare" preventive visit, is a comprehensive assessment provided within a member's first 12 months of Medicare Part B enrollment. The IPPE promotes overall health and wellness through disease prevention, early detection, and health risk assessment. This visit helps the provider establish a baseline understanding of the member's health status, identify preventive care needs, and develop a personalized plan for maintaining health and preventing illness.

Initial Preventive Physical Exam Components

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

- Medical and social history, including risk factors for disease.
- Review of functional ability, safety, and hearing status.
- Measurement of height, weight, BMI, blood pressure, and vision.
- Depression screening and behavioral health assessment.
- Review of health risk factors, including tobacco and substance use.
- End-of-life planning discussion, when agreed to by the member.
- Education and counseling on preventive services and screenings.
- Development of a personalized prevention plan, including referrals and follow-up care as appropriate.
- Electrocardiogram (EKG/ECG) completion or referral, if applicable.
- Documentation of findings, diagnoses, and recommendations for ongoing care and preventive services.
- PCPs must arrange appropriate follow-up, diagnostic evaluation, referrals, and treatment services for any identified risk factors, abnormal findings, or health conditions identified during the IPPE.

Note: The IPPE is a one-time Medicare preventive benefit available only during the first 12 months following Medicare Part B enrollment. Unlike the IHA, the IPPE is not waived based on the presence of a complete and current medical record. If a member is simply transferring from another Medicare insurance plan to CenCal CareConnect and has been on Medicare Part B for longer than 12 months, they are no longer eligible for an IPPE and providers should then conduct an Annual Wellness Visit according to CMS established timeframes.

Member Outreach and Documentation Requirements
CenCal Health understands that in certain cases, members do not come in for physical exams for reasons beyond their PCP's control. In this case, PCPs are expected to make reasonable efforts to schedule the examinations for their assigned members on a routine basis. For members whom they have never seen, PCPs are required to actively outreach to members when they first enroll to schedule the IHA or IPPE within designated time frames. If a member does not receive the appropriate services as required, the PCP must document attempts made to contact the member and the member's non-compliance.

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

Provider Reports
All provider notifications regarding members in need of an IHA or IPPE are communicated through monthly reports available on CenCal Health's Provider Portal in the Coordination of Care Section – Assigned Members tab.

For additional training on the portal, please contact CenCal Health's Webmaster via email at webmaster@cencalhealth.org.

Monitoring
CenCal Health conducts ongoing medical record audits to ensure all required components are addressed during an IHA/IPPE visit, including the completion and documentation of timely follow-up for abnormal findings, as well as the documentation of any refusals. Findings are shared and discussed with audited PCPs. Additionally, overall findings are shared network-wide to ensure continuous improvement.

DHCS maintains oversight of the IHA contractual requirements and performance expectations applicable to CenCal Health and its network providers. To demonstrate compliance with IHA program requirements, CenCal Health monitors implementation and completion of required activities and reports IHA-related performance and compliance information through the annual DHCS Medical Audit process and upon request by DHCS. CenCal Health maintains documentation supporting compliance with IHA requirements and works collaboratively with providers to address identified opportunities for improvement, ensure corrective actions are implemented when necessary, and support ongoing adherence to DHCS contractual obligations.

Pay for Performance
CenCal Health's Quality Care Incentive Program (QCIP) encourages timely IHA visits through measures like Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits, Developmental Screening in the First Three Years of Life, Breast Cancer Screening, and Cervical Cancer Screening.

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

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

Medi-Cal Population	CPT Billing Codes	ICD-10 Codes
Preventive visit, new patient	99381 - 99387	No restriction
Preventive visit, established patient	99391 - 99397	No restriction
Obstetrical care	59400, 59510, 59610, 59618 HCPCS: Z1032, Z1034, Z1038, Z6500	Prenatal care: Z34.0–Z34.93 (for normal pregnancies), O09.0–O09.93 (for high-risk pregnancies) Postpartum care: Z39.0–Z39.2
CenCal Care Connect Population	**HCPCS Billing Codes**	**ICD-10 Codes**
Initial preventive physical examination	G0402	No restriction
Initial annual wellness visit	G0438	No restriction
Subsequent annual wellness visit	G0439	No restriction

Reference Links:

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

ACOG Standards and Guidelines
www.acog.org/clinical/clinical-guidance/clinical-practice-guideline

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

Department of Health Care Services (DHCS)

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

All Plan Letter (APL) 23 - 005: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

All Plan Letter (APL) 26-015: Immunization Requirements
www.dhcs.ca.gov/file/apl-26-015/

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

CenCal Health's Quality Care Incentive Program (QCIP)
www.cencalhealth.org/providers/quality-of-care/quality-care-incentiveprogram/

Medicare Wellness Visits
www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E6: Adverse Childhood Experiences Screening

Adverse Childhood Experiences (ACEs) screening helps identify children and adults who may have experienced trauma during the first 18 years of life. ACEs, including exposure to abuse, neglect, or household dysfunction, can have lasting effects on physical, behavioral, and mental health, including chronic disease, depression, substance use, and other high-risk behaviors.

Initial Health Appointments

PCPs are required to perform an Initial Health Appointment (IHA) for newly assigned members within the timeframes outlined in section E5: Initial Health Appointment. For members less than 21 years of age, the IHA must provide, or arrange for the provision of, ACEs screening. For adult members, it is strongly encouraged to be completed at the same time. Completing ACEs screenings for both adult and pediatric members is an important opportunity to better understand member needs and support compassionate, trauma-informed care. When integrated into routine care, ACEs screening promotes earlier identification of risk, connects members to appropriate interventions and supports, and helps healthcare teams address underlying drivers of health disparities while fostering resilience across the lifespan.

Training and Certification
The California Department of Health Care Services (DHCS), in partnership with the California Office of the Surgeon General, established the ACEs Aware initiative to support standardized ACEs screening, trauma-informed care training, and early identification of members at risk for ACEs-Associated Health Conditions related to toxic stress. Completion of the required state-sponsored training and provider self-attestation supports DHCS compliance expectations for eligible ACEs screening reimbursement.

Early Identification of ACEs and timely connection to appropriate interventions, resources, and other supports can improve the health and well-being of individuals and families. The two-hour online curriculum will provide Continuing Medical Education (CME) and Maintenance of Certification (MOC) credits. To sign up, go to: www.acesaware.org

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

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

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

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

Coding *of the screening is dependent on the resulting score*.

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

Screening Tools
The ACEs questionnaire for adults (ages 18 years and older) and the Pediatric ACEs and Related Life-events Screener (PEARLS) tools for children (ages 0 to 19 years) are both forms of ACEs screening. Both tools are acceptable for members aged 18 or 19 years. The ACEs screening portion (Part 1) of the PEARLS tool is also valid for use to conduct

ACEs screenings among adults ages 20 years and older. If an alternative version of the ACEs questionnaire for adults is used, it must contain questions on the 10 original categories of ACEs to qualify.

10 original ACE categories:

- Abuse
  - Physical
  - Emotional
  - Sexual
- Neglect
  - Physical
  - Emotional
- Household Dysfunction
  - Parental incarceration
  - Mental illness
  - Substance dependence
  - Separation or divorce
  - Intimate partner violence

The ACEs questionnaire and the PEARLS tool are available at the following link: www.acesaware.org/learn-about-screening/screening-tools/

Response Framework:

Referrals and Interventions:
When ACEs screenings are completed, providers should have processes in place to connect members to appropriate treatment options, including behavioral health specialists, care coordination resources, and timely follow-up support.

- For additional information on accessing behavioral health services, please refer to the Mental Health Services Flyer located on the CenCal Health website.
- To connect a member with a CenCal Health navigator for care coordination related to psychotherapy or medication management, please complete the Behavioral Health Care Coordination Request Form.
- For questions or additional support, providers may contact the CenCal Health Behavioral Health Call Center at 1-877-814-1861.

Documentation Requirements
ACEs screening documentation must be retained in the member's medical record and made available upon request to support audit readiness, DHCS compliance validation, and applicable regulatory requirements. Providers are required to document the following:

- The use of an appropriate screening tool, including the name of the tool used
- Review of the completed screening
- Screening Results
- Interpretation of results

- What was discussed with the patient and/or family
- Any appropriate actions taken (Referrals or Interventions)

To support care coordination, continuity of care, accountability, and audit readiness, ACEs screening documentation must be retained in the member's medical record and made available upon request in accordance with applicable state and federal privacy requirements and regulation standards.

Information, materials, screening tools, and training opportunities can be found at ACESAware.org, or by emailing info@ACESAware.org.

Reference Links:

Provider Toolkit: Screening and Responding to the Impact of ACEs and Toxic Stress www.acesaware.org/wp-content/uploads/2020/05/ACEs-Aware-Provider-Toolkit-5.21.20.pdf

ACE Screening Sample Scripts for Pediatric Clinical Teams www.acesaware.org/wp-content/uploads/2021/09/ACEs-Aware-Sample-Scripts-for-Pediatric-Clinical-Teams.pdf

Pediatric Resiliency Collaborative Resource Guide Binderhttps://stmlcottagehealthncus001.blob.core.windows.net/public/PeRC_binder.pdf

Adverse Childhood Experience Screening: A Guide for Providers: www.cencalhealth.org/providers/adverse-childhood-experiences-screening-a-guide-for-providers/

All Plan Letter: Direct Payments for Adverse Childhood Experience Screening Services: www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-017.pdf

This section applies to the following CenCal Health programs:

Medi-Cal

E7: Vaccines for Children (VFC) & Declinations Process

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

Providers who are enrolled in the VFC program have access to all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Providers who would like to enroll in the VFC program may do so through eziz.org.

CenCal Health providers may also contact the Provider Relations Department at 805-562-1676 for support in enrolling in the VFC program.

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

This section applies to the following CenCal Health programs:

Medi-Cal

E8: Medi-Cal for Kids & Teens

CenCal Health network providers 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 Medi-Cal for Kids & Teens benefit (formerly known as Early and Periodic Screening, Diagnostic, and Treatment [EPSDT]) as described in Title 42 of the United States Code section 1396d(r), W&I Code section 14132(v) and APL 23-005.

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

Medi-Cal for Kids & Teens services must be provided to all members under 21 years of age, in accordance with the American Academy of Pediatrics (AAP) Bright Futures Guidelines and the age-specific assessments and services outlined in the Periodicity Schedule, including anticipatory guidance provided during preventive health visits. The AAP regularly publishes updated tools and resources for use by clinicians and state agencies.

- At each non-emergency primary care visit with a member under 21 years of age, the member (if an emancipated minor), or the parent(s) or guardian of the member, is advised of the children's preventive services due and available from CenCal Health.
- When a request is made for children's preventive services by the member, the member's parent(s) or guardian, or through a referral from the local Child Health and Disability Prevention (CHDP) program, *an appointment must be made for the member to have a visit within 10 working days of the request*, unless member declines a visit within 10 working days of the request and another appointment date is chosen by the member.

- Documentation must be entered in the member's medical record indicating receipt of preventive services in accordance with the AAP Bright Futures Guidelines.
- All refusals of children's preventive services must be documented in the member's medical record indicating the services were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of those services.

Medical Necessity

- Medi-Cal for Kids & Teens services are medically necessary or a medical necessity if they correct or ameliorate defects and physical or behavioral health conditions discovered through screening as set forth in Title XIX of the Social Security Act, Section 1905(r)(5) and in Welfare and Institutions Code (W&I Code), Section 14059.5(b)(1).
- PCPs must arrange for all medically necessary services identified at a preventive screening or other visit identifying the need for treatment, either directly or through referral to appropriate agencies, organizations, or individuals.
- All medically necessary services must be initiated in a timely manner, as soon as possible, *but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up*.
- If members less than 21 years of age are not eligible or accepted for medically necessary targeted case management services by a regional center or local government health program, CenCal Health will arrange comparable services for the member.
- CenCal Health provides appointment scheduling assistance and necessary transportation, including non-emergency medical transportation (NEMT) and non-medical transportation (NMT), to and from medical appointments for medically necessary services, including all services available through the Medi-Cal program, whether or not they are covered services.

Specialty Mental Health and Substance Use Services

- Specialty Mental Health Services (SMHS) and Substance Use Services are carved out benefits to the county's Mental Health Plan (MHP) and Drug Medi-Cal or Drug Medi-Cal Organized Delivery System Plans (DMC-ODS). CenCal Health will coordinate care with the MHP for all medically necessary services.
- Additional care coordination and case management services are provided, when appropriate or upon member request, to support the member's medical and behavioral health needs.

Medi-Cal for Kids & Teens: Guidance for Members

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

Provider Training and Attestation
California's managed care plans, including CenCal Health, must ensure that all Medi-Cal licensed providers receive proper education and training regarding Medi-Cal for Kids & Teens at least every two years. This training aims to strengthen understanding and awareness of Medi-Cal for Kids & Teens among Medi-Cal managed care plan-enrolled providers and increase access to children's health services.

DHCS guidance and All Plan Letter 23-005, state that all provider groups and network providers must attest to completing the training biannually. Provider training resources and attestation can be located online at www.cencalhealth.org/providers/care-guidelines/medi-cal-for-kids-teens-services/.

Monitoring
CenCal Health conducts ongoing medical record audits to ensure all required components are addressed during Initial Health Appointments or periodic well-child visits, including the completion and documentation of timely follow-up for abnormal findings, as well as the documentation of any refusals. Findings are shared and discussed with audited PCPs. Additionally, overall findings are shared network-wide to ensure continuous improvement. Cencal Health's year-round medical record program ensures all required components of Medi-Cal for Kids & Teens are completed including appropriate preventive medical, dental, vision, hearing, mental health, substance use disorder, developmental, and specialty services, as well as all medically necessary services to address any defects, illnesses, or conditions identified.

Provider Reports
Gaps in care reports are made available to providers through the Provider Portal to assist with identifying members due for preventive services and recommended screenings. Providers are expected to use available reports to support outreach efforts, improve timely completion of preventive services, and address identified care gaps. Information regarding provider performance and quality measures may be incorporated into quality improvement activities and provider education initiatives.

For additional information regarding provider reports, refer to **Section L4: Quality Care Incentive Program** and **Section E5: Initial Health Appointment**, or contact the Population Health team at populationhealth@cencalhealth.org.

CenCal Health's Quality Care Incentive Program (QCIP)
CenCal Health's Quality Care Incentive Program (QCIP) encourages timely provision of screening and preventive services for members under 21 years of age through the addition of measures such as Child and Adolescent Well-Care Visits and Developmental Screening in the First Three Years of Life. Refer to CenCal Health's Quality Care Incentive Program website for a full list of QCIP measures.

Member Outreach
CenCal Health supports its PCPs by identifying members who have not received Medi-Cal for Kids & Teens screening services or AAP Bright Futures preventive services by:

- Ensuring outreach to these members in a culturally and linguistically appropriate manner to increase utilization of clinically recommended services in accordance

with established guidelines. For additional information, please contact the Health Promotion team at: healtheducation@cencalhealth.org
- CenCal Health performs monthly educational outreach to members who are overdue for key preventive services, including key Medi-Cal for Kids & Teens services. Lists of members who received outreach are posted in the Provider Portal each month under Wellness and Prevention campaigns.

Reference Links:
DHCS APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the age of 21
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

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

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

DHCS Medi-Cal for Kids & Teens - EPSDT - Provider Training
www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/EPSDT-Provider-Training-BD-June-2024.pdf

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

CenCal Health Medi-Cal for Kids & Teens - EPSDT – Services Training & Attestation
www.cencalhealth.org/providers/care-guidelines/medi-cal-for-kids-teens-services/

This section applies to the following CenCal Health programs:

Medi-Cal

E9: Developmental Screenings

Developmental screenings use standardized questions to see if a child's motor, language, cognitive, social, and emotional development are on track for their age. The American Academy of Pediatrics (AAP) recommend developmental screening for all children at 9, 18, and 30 months of age, or as medically necessary.

Developmental Screening and Testing CPT Codes	
96110	General Developmental Screening
96110 mod KX	Autism Spectrum Disorder (ASD) Screening
96127	Brief emotional/behavioral assessment, per standardized instrument
96112	Developmental test administration, first hour
96113	Developmental test administration, each additional 30 minutes

Frequency Limits
96110 is limited to two screenings per year, per member. 96112 and 96113 are each limited to one per year, per member. 96127 is limited to two per day, per provider.

Note on 96112/96113: These codes are reimbursable when a child has signs concerning developmental delay or loss of previously acquired developmental skills, or when a developmental screening test is abnormal — they follow up on a concerning screen rather than substitute for routine screening.

Reference Links:
For additional details on how to maximize reimbursement of developmental screenings, please refer to:

- Developmental Surveillance Resources for Pediatricians
- EPSDT Provider Training BD June 2024 – see pages 15-16

This section applies to the following CenCal Health programs:

Medi-Cal

E10: Depression Screenings

The U.S. Preventive Services Task Force (USPSTF) and American Academy of Family Physicians recommend screening for depression in the general adult population. Additionally, the USPSTF recommends screening children and adolescents 12 to 18 years of age for major depressive disorder.

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

- Patient Health Questionnaire (PHQ), which is used as a self-report measure designed to screen depressive symptoms. There are two-item and nine-item Patient Health Questionnaires (PHQs). If the PHQ-2 is positive for depression, the PHQ-9 or a clinical interview should be administered.
    - There is a PHQ-9 for Adolescents
- Beck Depression Inventory (BDI)The BDI can be used for ages 13 to 80.
    - The Children's Depression Inventory (CDI) is a modification of the Beck Depression Inventory for use with children and adolescents 7 to 17 years old.

Depression Screening HCPCs codes	
G8431	Screening for Depression, (Positive Result with follow-up plan), limit one per year per provider
G8510	Screening for Depression, (Negative Result)

Frequency Limits
G8431 and G8510 are each limited to one screening per year, per provider.

Reference Link:
[APA Depression Assessment Instruments]

This section applies to the following CenCal Health programs:

Medi-Cal

E11: Behavioral Health Treatment

CenCal Health covers medically necessary behavioral health treatment (BHT) for individuals under the age of 21 under Medi-Cal for Kids & Teens (formerly known as the EPSDT benefit). BHT services are covered so long as the services have an ameliorative or maintenance purpose. Behavioral health treatment (BHT) services provide a variety of evidence-based behavioral interventions, including but not limited to Applied Behavioral Analysis (ABA).

CenCal Health covers all medically necessary BHT services, including supplementary BHT services and services needed to fill gaps when a Local Education Agency (LEA) discontinues services identified in a member's Individualized Family Service Plan (IFSP), Individualized Education Program (IEP), or Individualized Health and Support Plan (IHSP). CenCal Health also coordinates with Regional Centers to avoid duplicating BHT services provided under a member's Individual Program Plan (IPP).

Recommendation for BHT Services

No specific diagnosis is necessary to start behavioral health treatment. An ABA recommendation from a qualified provider (physician/psychologist) is required to initiate the Functional Behavioral Assessment (FBA) process with a BHT provider, which should be submitted through an ABA Recommendation (RAFB). FBA requests are then submitted by the BHT provider via a Treatment Authorization Request (TAR 50-1) and are approved for a 2-month period.

Authorization Process

After completing the FBA assessment, the BHT provider must submit a TAR 50-1 to CenCal Health for up to six months of services. CenCal Health reviews initial and ongoing BHT treatment requests for medical necessity, including the requested services, treatment intensity, frequency, duration, and clinical rationale, based on the information submitted by the provider and applicable Medi-Cal/EPSDT requirements and clinical guidelines. The FBA report should be uploaded through the Provider Portal, secure link, or faxed to 805-681-3070. Authorization timelines follow Medi-Cal guidelines as described in Section H, including DHCS's EPSDT timely access standard, which

requires diagnostic and treatment services to be initiated no later than 60 calendar days following a visit that identifies a need for follow-up.

BHT HCPCs Codes	
H0031* per 15 min	Assessment
H0032 per 15 min	Treatment Plan development (including supervision)
H2014 per 15 min	Skills Training and development (individual only)
H2019 per 15 min	Therapeutic Behavioral Services
S5111 per session	Home care/family training

*H0031 code to be approved only one time for the FBA. Reassessments completed every six months can be billed using H0032.

BHT CPT Codes	
97151 per 15 min	Behavior identification assessment, face-to-face with patient and/or guardian(s)/caregiver(s)
97152 per 15 min	Observational behavioral follow-up assessment, administered by one technician, with physician or other qualified provider direction, interpretation, and report
97153* per 15 min	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient
97154* per 15 min	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients
97155 per 15 min	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare provider with one patient
97156 per 15 min	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare provider (with or without the patient present)
97157 per 15 min	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare provider (without the patient present)
97158 per 15 min	Adaptive behavior treatment social skills group, administered by physician or other qualified healthcare provider, face-to-face with multiple patients

No Modifiers are required for a Qualified Autism Service Provider. For other providers, use the following:

- HO – Midlevel Qualified Autism Service Professional
- HM – Qualified Autism Service Paraprofessional

BHT provider type definitions		
Provider Type	Provider Qualifications	Services they can perform

Qualified Autism Service Provider (Supervisor)	Board Certified Behavior Analyst (BCBA)	FBA's, Re-assessments, Treatment plan modifications, Direct therapy, Supervision of direct therapy
	Licensed Practitioner (LP) *A	
Qualified Autism Service Professional (Mid-level supervisor)	Associate Behavior Analyst (BCaBA)	FBA's, Direct therapy, Supervision of direct therapy
	Behavior Analyst (state-licensed; a distinct credential from Board Certified Behavior Analyst)	FBA's, Re-assessments, Treatment plan modifications, Direct therapy, Supervision of direct therapy
	Behavior Management Assistant *B	FBA's, Direct therapy
	Behavior Management Consultant *C	FBA's, Re-assessments, Treatment plan modifications, Direct therapy, Supervision of direct therapy
Qualified Autism Service Paraprofessional (Behavior therapist)	Paraprofessional *D	Direct therapy

*A – The following fall under LP, provided they have completed 12 semester units in Applied Behavior Analysis (ABA) and have two years of experience designing and implementing behavior modification intervention services: a licensed physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

*B – The assistant may conduct listed activities in the table only if they are under the direct supervision of a BCBA or Behavior Management Consultant, and they meet either of the following requirements:

- Possess a Bachelor of Arts or science degree and has either: 12 semester units in ABA and one year of experience in designing and/or implementing behavior modification intervention services; or two years of experience in designing and/or implementing behavior modification intervention services; or
- Is registered as either a psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or as an Associate Licensed Clinical Social Worker.

*C - A consultant is someone who meets the following requirements:

- Shall have completed twelve semester units in ABA and possess a license and experience as specified below:
- Possesses a valid license as a psychologist from the Medical Board of California or Psychology Examining Board; or
    - Licensed Clinical Social Worker; or
    - Is a Licensed Marriage and Family Therapist; or

- Is any other licensed professional whose California licensure permits the design and/or implementation of behavior modification intervention services.
- Have two years of experience designing and implementing behavior modification intervention services.

*D - An unlicensed and uncertified individual who meets all the following:

- Is employed and supervised by a qualified autism service provider to provide direct therapy pursuant to a treatment plan developed and approved by the QAS Provider and,
- Meets one of the following, as certified by a QAS Provider or an entity/group employing QAS Providers:
  - Has a high school diploma or equivalent, has completed 30 hours of competency-based training designed by a BCBA, and has six months of experience working with persons with developmental disabilities; or
  - Possesses an associate's degree in a human, social, or educational services discipline, or a degree/certification related to behavioral management from an accredited community college or educational institution, and has six months of experience working with individuals with developmental disabilities.

When a covered behavioral or mental health service is furnished by a pre-licensed professional under appropriate supervision, the claim must clearly identify the fully licensed supervising professional responsible for the service and must also disclose the individual who rendered the service. The supervising professional must be appropriately licensed, credentialed, contracted, and authorized to bill for the service.

For professional claims, enter the supervising/billing provider information in the applicable billing and rendering provider fields. When the pre-licensed professional is not eligible to bill independently, the pre-licensed professional's name and National Provider Identifier (NPI) must be included in the Remarks section of the professional claim form to identify the individual who rendered the service.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E12: Mental Health Services

CenCal Health covers mental health services that address all DSM-5 diagnoses as the primary focus of treatment, apart from conditions that are solely neurocognitive or substance use-related. However, services for these excluded conditions may be covered when they co-occur with a qualifying mental health disorder and meet the criteria for non-specialty mental health services (NSMHS).

The following NSMHS are covered by CenCal Health, and include:

a. Mental health evaluation and treatment, including individual, group, and family psychotherapy.
b. Outpatient services for the purpose of monitoring drug therapy.
c. Outpatient laboratory, drugs, supplies, and supplements.
d. Psychiatric consultation with a member to establish medical necessity for medication management of a psychiatric or behavioral disorder.

Services Requiring Prior Authorization:

a. Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS) for the treatment of major depressive disorders or dysthymia, when clinically indicated. Members must be 15 years of age or older.
b. Psychological and neuropsychological testing may be provided to evaluate a mental health condition when clinically indicated. An evaluation must determine that the psychological or neuropsychological testing is clinically appropriate and medically necessary.

Any services that exceed frequency limitations, such as a psychiatric diagnostic evaluation, which has a frequency limit of one per day.

Psychiatric Diagnostic Evaluation

Diagnostic Evaluation CPT Codes	
90791	Psychiatric Diagnostic Evaluation without medical services
90792	Psychiatric Diagnostic Evaluation with medical services
90785	Interactive Complexity

Psychotherapy

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

Children under the age of 21 with persistent mental health symptoms, but no diagnosed mental health condition, are entitled to individual, group, or family therapy, consistent with EPSDT requirements. For individual or group therapy, use diagnosis code Z71.89. For family therapy, DHCS permits up to five sessions using diagnosis code Z71.89 before a formal diagnosis is required; if the member or their parent/guardian has a qualifying risk factor (e.g., foster care placement, exposure to trauma, parental mental illness), family therapy may continue without regard to the five-session threshold using diagnosis code Z65.9.

Adult members aged 21 and older are entitled to up to six individual psychotherapy sessions per provider, per year, prior to being diagnosed with a mental health condition. Providers should submit these claims using diagnosis code F99 (mental disorder, not otherwise specified) as a placeholder until a formal diagnosis is established. For members receiving outpatient psychotherapy for mild to moderate

mental health conditions, individual psychotherapy is generally expected to occur approximately once per week, or four sessions per month. More frequent treatment may be clinically appropriate based on the member's individual needs and should be supported by documented clinical rationale and medical necessity.

Providers are encouraged to make reasonable efforts to contact members who miss an initial psychotherapy appointment and offer to reschedule when clinically appropriate, with outreach attempts documented in the clinical record.

Individual therapy is limited to a maximum of 90 minutes per day by the same provider. When 90 minutes of individual psychotherapy is provided, providers should bill two units of CPT 90834. Providers will submit claims using the following code and a primary ICD-10 code.

Individual Therapy CPT codes	
90832	Psychotherapy, 30 min
90834	Psychotherapy, 45 min
90837	Psychotherapy, 60 min
90839	Psychotherapy for crisis, first 60 min
90840	Psychotherapy for crisis, each additional 30 min
90880	Hypnotherapy

Family Therapy CPT codes	
90846	Family Psychotherapy (without client present) 50 min
90847	Family Psychotherapy (with client present) 50 min
90849	Multiple-family group therapy

**Couples Therapy can be billed using 90846 or 90847 as applicable.*
**CPT codes 90846, 90847, 90849 and 90853 may not be billed on the same day for the same recipient.*

Group Therapy CPT code	
90853	Group psychotherapy

Case Conference CPT codes	
99366	Medical team conference, recipient and/or family present, per 30 min
99368	Medical team conference, recipient and/or family not present, per 30 min

When a member's mental health needs are determined to meet a higher level of care, a transition of care between delivery systems should be initiated. The decision to transition a member between non-specialty and specialty levels of care is made by a clinician through a patient-centered, shared decision-making process and is

documented in the member's clinical record, including the member's diagnoses, symptoms, history, medications, and requested services.

When a covered behavioral or mental health service is furnished by a pre-licensed professional under appropriate supervision, the claim must clearly identify the fully licensed supervising professional responsible for the service and must also disclose the individual who rendered the service. The supervising professional must be appropriately licensed, credentialed, contracted, and authorized to bill for the service.

For professional claims, enter the supervising/billing provider information in the applicable billing and rendering provider fields. When the pre-licensed professional is not eligible to bill independently, the pre-licensed professional's name and National Provider Identifier (NPI) must be included in the Remarks section of the professional claim form to identify the individual who rendered the service.

Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS)

Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS) requires pre-service authorization. Providers must submit a Behavioral Health Treatment Authorization Request (50-1) with a completed Transcranial Magnetic Stimulation (TMS) Services Pre-Service Authorization Request Form to the Behavioral Health Department via fax 805-681-3070, Provider Portal, or the Behavioral Health Department.

TMS CPT codes	
90867	Therapeutic repetitive TMS treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive TMS treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive TMS treatment; subsequent motor threshold re-determination with delivery and management

Psychological and Neuropsychological Testing

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

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

Psychological and Neuropsychological Testing CPT codes	
96130	Psychological testing; first hour

96131	Psychological testing; each additional hour
96132	Neuropsychological testing evaluation services; first hour
96133	Neuropsychological testing evaluation services; each additional hour
96136	Psychological or neuropsychological test administration and scoring, two or more tests; first 30 minutes
96137	Psychological or neuropsychological test administration and scoring, two or more tests; each additional 30 minutes
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

Dyadic Services

Dyadic Behavioral Health HCPC codes	
H1011	Dyadic Behavioral Health Well-Child Visit
T1027	Dyadic Family Training and Counseling for Child Development, per 15 minutes
H2015	Dyadic Comprehensive Community Support Services, per 15 minutes
H2027	Dyadic Psychoeducational Services, per 15 minutes

Dyadic services must be billed with Modifier U1. When services are provided to a Medi-Cal-enrolled parent or caregiver, claims are billed using the parent/caregiver's CenCal Health ID with Modifiers U1 and HB. When services are provided to a parent or caregiver who is not enrolled in Medi-Cal, claims are billed using the child's CenCal Health ID with Modifiers U1 and UK.

Education and Outreach

CenCal Health is committed to member and provider outreach, education, and the assessment of member experiences concerning NSMHS.

- CenCal Health's annual outreach and education plan is tailored for members and Primary Care Providers (PCPs) regarding the NSMHS covered by the Plan. Key components of this plan include:
    - "No Wrong Door" Policy: Ensuring that all members can access services without barriers.
    - Cultural and Linguistic Appropriateness: Adhering to standards that respect the diverse backgrounds of our members.
    - Stigma Reduction Best Practices: Implementing strategies to minimize stigma associated with mental health services.
    - Multiple Access Points: Providing various channels for members to reach out and receive NSMHS.
- This comprehensive approach aims to enhance member engagement and improve overall experience with mental health services.

Behavioral Health Resources
To make a referral or access care coordination and navigation services, please contact the Behavioral Health Department.

CenCal Health Contact Numbers
CenCal Health Behavioral Health Department

- Member Line: 877-814-1861
- Provider Line: 805-562-1600
- Fax number: 805-681-3070

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

County Behavioral Health Resources
Santa Barbara County Department of Behavioral Wellness

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

San Luis Obispo Department of Behavioral Health

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

CenCal CareConnect Behavioral Health Services
CenCal CareConnect members have access to behavioral health services currently covered by Medicare and Medi-Cal. CenCal Health directly manages the CenCal CareConnect behavioral health benefits. A behavioral health provider must contract with CenCal Health to provide CenCal CareConnect behavioral health services. Available services include:

- **Outpatient mental health services,** including, but not limited to, the following:
    - Individual and group mental health evaluation and treatment
    - Intensive Outpatient Program (IOP) services
    - Partial Hospitalization Program (PHP) services
    - Psychological testing to evaluate mental health condition
    - Electroconvulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
- **Inpatient mental health services**
- **SABIRT Opioid Treatment Program (OTP) services**

Prior Authorization
CenCal CareConnect does not require prior authorization for most outpatient behavioral health services.

However, the following services do require prior approval:

a. Inpatient psychiatric services (IP)

b. Intensive Outpatient Program (IOP)
c. Partial Hospitalization Program (PHP)
d. Psychological testing
e. Electroconvulsive therapy (ECT)
f. Transcranial magnetic stimulation (TMS)
g. Opioid treatment Program (OTP) services

Behavioral Health Resources
To make a referral or access care coordination and navigation services, please contact the Behavioral Health Department.

CenCal Health Contact Numbers
CenCal Health Behavioral Health Department

- Member Line: 877-814-1861
- Provider Line: 805-562-1600
- Fax number: 805-681-3070

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E13: Substance Use Services

CenCal Health covers substance use disorder services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older and pregnant members. These services are covered in the primary care setting, and tobacco, alcohol, and illicit drug screenings are completed in accordance with the recommendations of the American Academy of Pediatrics Bright Futures for Children and the United States Preventive Services Taskforce Grade A and B recommendations for adults. CenCal Health also covers Medications for Addiction Treatment (MAT), including treatment for opioid use disorder through medical providers in primary care, inpatient hospital, emergency department, and other contracted medical settings. The County Drug Medi-Cal Organized Delivery System (DMC-ODS) covers substance use disorder treatment, including outpatient and intensive outpatient treatment, residential treatment, withdrawal management, narcotic treatment programs, MAT, and recovery services. MAT through DMC-ODS may be provided as a standalone service or as part of these treatment programs.

Substance Use Billing codes	
99406	Tobacco cessation, 3 to 10 minutes
99407	Tobacco cessation, more than 10 minutes
G0442	Annual alcohol misuse screening, 15 minutes

H0049	Drug use screening
H0050	Alcohol and drug services, brief intervention

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E14: Non-Emergency Medical Transportation Services and Non-Medical Transportation

Non-emergency medical transportation (NEMT) services are available for members whose medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and specialized transportation is required for the purpose of obtaining needed medical care. Services will be in accordance with DHCS Guidelines (APL 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses).

NEMT requires prior authorization (TAR). A completed and signed 'Physician Certification Statement' (PCS) form is required to authorize NEMT. The PCS form can be completed and signed by the member's physician, dentist, podiatrist, physical or occupational therapist, mental health or substance use disorder provider, or physician extender. To prevent denials or delays of transport, a completed PCS form with the appropriate NEMT type, start date, and duration must be received by CenCal Health. Ventura Transit System (VTS) is CenCal Health's transportation vendor. To schedule transportation services, members or providers may contact VTS directly at 855-659-4600.

Prior authorization is not required when the member is being transferred from an emergency department to an inpatient setting or from an acute care hospital immediately following an inpatient stay at the acute level of care to a skilled nursing facility, an intermediate care facility, embedded psychiatric units, free-standing psychiatric inpatient hospitals, or psychiatric health facilities.

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

- **Mode of Transportation:** The physician is required to identify the mode of transportation to be used when receiving these services (ambulance, gurney/litter van, wheelchair van, or air transport).
- **Dates of Service and Duration:** The physician is required to provide the start and end dates for the prescribed NEMT service; authorizations may be for a maximum of 12 months.
- **Diagnosis:** The physician is required to state the member's diagnosis.
- **Functional Limitations and Justification:** The physician is required to provide the member's specific physical and medical limitations that preclude their ability to reasonably ambulate without assistance or be transported by public or private vehicles.
- **Certification Statement:** The physician is required to certify that medical necessity criteria were met to determine the prescribed mode of transportation.

To view or print the Physician Certification form and instructions on how to submit electronically, please go to www.cencalhealth.org. To submit electronically through the Provider Portal, please go to www.cencalhealth.org and use the Provider Login page.

Completed and signed Physician Certification forms should be submitted to the CenCal Health Utilization Management (UM) Department via:

- Electronically through the Provider Portal or
- CenCal Health UM Fax: 805-681-3071

The following four modalities of NEMT transportation are available in accordance with the Medi-Cal Provider Manual and the California Code of Regulations (CCR):

1. **Ambulance:**
    a. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
    b. Transfers from an acute care facility to another acute care facility.
    c. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
    d. Transport for members with chronic conditions who require oxygen if monitoring is required.
2. **Gurney/Litter Van:** For members whose medical and physical condition does not meet the need for NEMT via ambulance, but meets both of the following:
    a. Requires that the member be transported in a prone or supine position because the member is incapable of sitting for the period of time needed to transport.
    b. Requires specialized safety equipment over and above what is normally available in passenger cars, taxicabs, or other forms of public conveyance.
3. **Wheelchair Van:** For members whose medical and physical condition does not meet the need for NEMT via gurney/litter van, but meets any of the following:
    a. Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
    b. Requires that the member be transported in a wheelchair and receive assistance to and from the residence, vehicle, and/or place of treatment because of a disabling physical or mental limitation.
    c. Requires specialized safety equipment that is considered over and above what is normally available in private vehicles, taxicabs, or other forms of public conveyance.
4. **Air:** NEMT via air is necessary only when practical considerations render ground transportation infeasible due to the member's medical condition. The medical necessity for NEMT via air must be included in the Physician Certification form.

Non-Medical Transportation (NMT)
Non-medical transportation services are covered and provided through CenCal Health for all Medi-Cal covered services, including those not covered by CenCal Health's contract. Services that are not covered under the CenCal Health contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

The following NMT services are covered:
Round-trip transportation for a member by passenger car, taxicab, bus, or other form of public or private conveyance (private vehicle), as well as mileage reimbursement for medical, mental health, or substance use treatment purposes when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers, or train tickets. Before getting approval for mileage reimbursement, a member must state to CenCal Health by phone, by email, or in person that they tried to obtain all other reasonable transportation choices but could not obtain one. The NMT request must be the least costly method of transportation that meets the member's needs.

- Round-trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions at their local pharmacy.
    - Members picking up medical supplies, prosthetics, orthotics, and other equipment.
    - Members requiring transportation from an out-of-county psychiatric hospital to their home or a crisis residential treatment facility.
- NMT must be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- CenCal Health may use prior authorization processes to approve NMT services.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at the time of the initial NMT authorization request.
- With the written consent of a parent or guardian, CenCal Health may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. CenCal Health must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service, and is responsible for ensuring all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

- CenCal Health does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to CenCal Health in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license.
    - Has no working vehicle available in the household.
    - Is unable to travel or wait for medical or dental services alone.
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Authorization

- VTS determines the transportation benefit to be provided to the member based on the outcome of a series of questions completed during the intake screening from a triage screening form provided by CenCal Health.
- If the NMT request is determined for a local CenCal Health/Medi-Cal contracted provider, no authorization is required, and VTS will coordinate the transport.
- If the NMT request is for an out-of-a-area trip, CenCal Health requires an authorization to be obtained from CenCal Health's Member Services Department. Once the authorization is in place, VTS will then coordinate the out-of-area transport.
- NMT services do NOT require a Physician Certification Statement (PCS) Form.

NMT does not apply if:

- An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service.
- You need assistance from the driver to and from the residence, vehicle, or place of treatment due to physical or medical condition.

Members and/or providers may contact Ventura Transit System (VTS) directly at 1-855-659-4600 for transportation services or CenCal Health's Member Services Department at 1-877-814-1861 for assistance.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E15: Oral Health

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

authorization for medical services required in support of dental procedures. Lastly, for members with complex oral health needs, particularly when oral health conditions impact chronic disease management, nutrition, or when behavioral health, cognitive, housing, or other social challenges create barriers to access to dental care, please contact CenCal Health's Care Management team to discuss available care coordination resources and referral options.

All members less than 21 years of age are **required** to receive a dental screening and an oral health assessment as part of every periodic assessment, with annual dental referrals beginning with the eruption of the member's first tooth or at 12 months of age (whichever occurs first) or when a referral is indicated based on assessment. Annual referral for dental care and treatment by one's Primary Care Provider (PCP) is one of the most compelling actions to motivate member follow-through to obtain vital dental care.

The American Academy of Pediatrics (AAP) and United States Preventive Services Task Force (USPSTF) recommend that PCPs apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. Once teeth are present, apply fluoride varnish to all children every three to six months in the primary care or dental office based on caries risk.

Importance of Fluoride Varnish

Topical application of fluoride varnish is a covered benefit for pediatric CenCal Health members. The early application of fluoride varnish protects the primary teeth and should be performed after the first teeth erupt until age 5.
https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/
https://www.cencalhealth.org/providers/care-guidelines/medi-cal-for-kids-teens-services/pediatric-oral-health/

CenCal Health's Pediatric Oral Health Webpage:
www.cencalhealth.org/providers/care-guidelines/medi-cal-for-kids-teens-services/pediatric-oral-health/

Billing for Fluoride Varnish

Use **CPT code 99188** - topical application. Reimbursable for children through age 5. Reimbursement includes all materials and supplies needed for the application.

Once teeth are present, treatment is covered up to three times in a 12-month period. Fluoride varnish can be swabbed directly onto the teeth in less than three minutes and sets within one minute of contact with saliva. The application requires no special dental equipment and can be applied with minimal training.

Fluoride varnish may be applied by:

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

For staff training or other questions, please contact our Population Health team at populationhealth@cencalhealth.org.

Monitoring

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

Annually, CenCal Health reports to DHCS the percentage of children ages 1 through 20 who received at least two topical fluoride applications within the measurement year as part of the defined set of performance measures that all Medi-Cal managed care plans are required to report, known as the Medi-Cal Managed Care Accountability Set (MCAS). See *Section L5: Performance Monitoring* for additional details.

Provider Reports

To monitor progress for this aspect of care, please refer to the QCIP section of the Provider Portal or reach out to qcip@cencalhealth.org.

CenCal Health's Quality Care Incentive Program (QCIP)

CenCal Health added "***Topical Fluoride for Children***" to its PCP Quality Care Incentive Program as a priority measure (QCIP) to improve the percentage of CenCal Health children 1-4 years of age who received at least two fluoride varnish applications. To learn more, visit:

CenCal Health's QCIP Webpage: www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

Reference Links:

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

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

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

DHCS All Plan Letter 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

Fluoride Use in Caries Prevention in the Primary Care Setting

https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E16: Pregnancy & Postpartum Members

Pregnant and Postpartum Care
In alignment with the American College of Obstetricians and Gynecologists (ACOG) and the Comprehensive Perinatal Services Program (CPSP), CenCal Health requires Network Providers to deliver comprehensive, timely, and individualized care to pregnant and postpartum members. Early identification of medical, behavioral, psychosocial, and social needs during pregnancy, coupled with ongoing postpartum support, is essential to improving maternal and infant health outcomes and reducing preventable complications.

Pregnant Member Care Guidelines
Network Providers rendering obstetrical care are required to:

1. Initiate prenatal care as early as possible during pregnancy.
2. Utilize a Comprehensive Risk Assessment (CRA) tool comparable to ACOG and CPSP standards, consistent with 22 CCR § 51348.
3. Complete and maintain documentation of the CRA in the member's medical record:
    - At the initial prenatal visit.
    - Once during the second trimester.
    - Once during the third trimester.
    - At the postpartum visit.
4. Assess and address medical/obstetrical, nutritional, psychosocial, behavioral health, and health education needs.
5. Provide appropriate prenatal screenings, education, referrals, and care coordination based on identified needs.
6. Coordinate care with Primary Care Providers, specialists, behavioral health providers, and community resources, as appropriate.

Postpartum Care Guidelines
The postpartum period is a critical time for both the birthing person and infant. More than 80 percent of maternal deaths are preventable, with most occurring between 7 and 365 days after childbirth. Timely, individualized postpartum care can help identify and address pregnancy-related complications, behavioral health conditions, and other health needs. Postpartum care should be provided as an ongoing process, with services and support tailored to the member's needs.
Postpartum care shall include:

1. Initial postpartum contact within three weeks of delivery.
2. Ongoing, individualized follow-up care based on the member's medical, behavioral, and psychosocial needs.
3. A comprehensive postpartum visit no later than 12 weeks postpartum.

Required Components of the Comprehensive Postpartum Visit
The comprehensive postpartum visit should include, as clinically appropriate:

- Assessment and follow-up of pregnancy- and delivery-related complications, including gestational diabetes, hypertensive disorders, infections, and cardiomyopathy.
- Mental health screening, including depression and anxiety.
- Lactation assessment, education, and support.
- Reproductive life planning and contraceptive counseling.
- Chronic disease management and coordination with primary care and specialty providers.
- Health behavior counseling, including nutrition and substance use.
- Referrals to community resources and social support services, including the **Women, Infants, and Children (WIC) Program**, as appropriate.

Members who experience miscarriage, stillbirth, or neonatal loss should receive timely follow-up, emotional support, and appropriate referrals.

Transitional Care Services (TCS)
In accordance with the January 2026 DHCS Population Health Management Policy Guide and APL 26-005, CenCal Health stratifies pregnant and postpartum members as **High Risk** or **Moderate Risk** to ensure appropriate care management and support. Pregnant and postpartum members shall receive care coordination services, including completion of the Birthing Supports Checklist, in collaboration with Network Obstetric Providers and TCS Care Managers. TCS services shall continue through resolution of identified needs and for at least **60 days following the end of pregnancy**, or **30 days following discharge from a postpartum hospitalization unrelated to delivery**, whichever is later.

TCS care coordination shall support completion of:

- The member's postpartum visit with a qualified medical provider.
- The infant's two-month well-child visit.
- Recommended follow-up care identified in discharge instructions.

Care Management Support
CenCal Health Care Management is available to support pregnant and postpartum members with **complex care coordination needs** or barriers to care. Care Management collaborates with providers to promote member engagement, connect members to resources, and support completion of required Comprehensive Risk Assessments (CRAs), prenatal and postpartum care, and recommended follow-up services. Please visit the CenCal Health website for steps on how to submit a referral:
www.cencalhealth.org/providers/case-management/

Billing
CenCal Health has carved out postpartum visits from the global reimbursement for obstetric care so that providers can bill for these visits separately as fee-for-service. This is an added financial incentive to complete timely postpartum care **initiated within three weeks after delivery, with ongoing care in accordance with the ACOG**

recommendations. OB providers do not receive a denial when billing globally without the inclusion of this service, so it is important to **bill for postpartum visits separately**.

- CPT code Z1038

If you have any questions regarding how to bill, please contact our Claims Services Representatives at 805-562-1038 or email CenCalClaims@cencalhealth.org.

Doula Services

Doula services are a covered Medi-Cal Benefit. CenCal Health members will be able to get support from a doula (birth worker) at no cost for prenatal and postpartum visits, as well as during labor and birth, miscarriage, and abortion visits. For a doula to be reimbursed for services, they need to be contracted with CenCal Health. For additional information, please reference Doula Services under Section E: Covered Benefits and Services of the Provider Manual or contact the Provider Relations Department at 805-562-1676 or email psrgroup@cencalhealth.org.

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

Member Outreach

CenCal Health performs monthly educational outreach to members who are recently postpartum. These educational campaigns provide educational information about how to care for oneself through 12 months postpartum, including nutrition, breastfeeding, mental health, physical activity, and more.

Lists of members who have received this outreach are posted in the Provider Portal each month under Wellness and Prevention campaigns.

For assistance with Provider Portal account access, please contact CenCal Health's Webmaster via email at webmaster@cencalhealth.org.

Reference Links:

ACOG Clinical Guidelines
www.acog.org/clinical

ACOG Committee Opinion No. 736. *Optimizing Postpartum Care*.
www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

California Code of Regulations Title 22 §51348. *Comprehensive Perinatal Services.*
www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/CPSP-Title22CPSPRegulations.pdf

California Department of Public Health (CDPH) Comprehensive Perinatal Services Program (CPSP) Provider Handbook:
www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

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

DHCS APL 26-005
www.dhcs.ca.gov/wp-content/uploads/2026/04/APL26-005.pdf

DHCS CalAIM: Population Health Management Policy Guide www.dhcs.ca.gov/wp-content/uploads/2025/10/PHM-Policy-Guide.pdf

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E17: Steps to Take for Tobacco Cessation

Documenting patient tobacco use (including cigarettes, cigars, chew, vapes, e-cigarettes, etc.) and providing brief clinical interventions is important to quality patient care. Clinician-delivered brief interventions enhance motivation and increase the likelihood of successful and multiple quit attempts.

The steps below outline CenCal Health's preferred methods for tobacco cessation.

1. Ask all adolescent, adult, and pregnant patients if they are current smokers or exposed to tobacco smoke. **Specifically, ask about the use of vapes/e-cigarettes.**

2. Document patient tobacco use using one of the following identification methods:
    - Add tobacco use as a vital sign in the chart or EMR system.
    - Report to CenCal Health these ICD-10 codes, if applicable, and also document in the medical record.
        - Tobacco Use Codes: ctri.wiscweb.wisc.edu/wp-content/uploads/sites/240/2017/09/icd10.pdf
        - Vape/E-cigarette Use Codes: www.cdc.gov/nchs/data/icd/Vapingcodingguidance2019_10_17_2019.pdf
    - Place a chart stamp in the medical chart.

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

4. Once you establish the appropriate cessation regimen for the patient, prescribe the appropriate cessation agent.
    - Please see medi-calrx.dhcs.ca.gov for the current formulary.

- If applicable, instruct the patient to take their prescription to the pharmacy for fulfillment.

5. Refer the patient to **individual, group, and telephone** counseling. Counseling is strongly recommended for cessation success. CenCal Health members can receive up to four counseling sessions of at least 10 minutes for up to two separate quit attempts per year. CenCal CareConnect members can receive up to eight counseling sessions within a 12-month period.

   Please note: All pregnant patients who smoke should be offered at least one face-to-face tobacco cessation counseling session per quit attempt.

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

Billing:
Use the following CPT codes for reimbursement for individual counseling:
- **99406**: Symptomatic; smoking and tobacco use cessation counseling visit, greater than 3 minutes, up to 10 minutes
- **99407:** Symptomatic; smoking and tobacco use cessation counseling visit; greater than 10 minutes

Group counseling
Refer the patient to a group cessation class. Contact the local Public Health Department for information on local classes and support services:
- **Santa Barbara County:** 805-681-5100
- **San Luis Obispo County:** 805-781-5500

Telephone counseling
Refer the patient to the *Kick It California* Helpline at 800-300-8086.
- Give the patient a flyer with contact information for Kick It California.
  - kickitca.myshopify.com/collections/all
- Or log onto Helpline's web referral to refer the patient directly. Helpline counselors will then contact the patient's personal phone.
  - www.kickitca.org/patient-referral

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

Notes:

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

Reference Links:

International Classification of Diseases (ICD)-10 Codes
https://ctri.wisc.edu/wp-content/uploads/sites/240/2017/09/icd10.pdf

Five Major Steps to Intervention (The "5A's")
www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.pdf

Patients Not Ready To Make A Quit Attempt Now (The "5 R's")
www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5rs.pdf

Kick It California
kickitca.myshopify.com/collections/all
www.kickitca.org/patient-referral

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

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

This section applies to the following CenCal Health programs:

Medi-Cal

E18: Whole Child Model (WCM) and California Children's Services (CCS)

As of July 1, 2018, CenCal Health began administering the Whole Child Model (WCM) for the California Children's Services (CCS) program for all eligible pediatric members (ages 0-20). The WCM is a delivery system that is in accordance with DHCS guidelines (APL 21-005, ***California Children's Services Whole Child Model Program***), which provides comprehensive, coordinated services for children and youth with special healthcare needs through a patient and family-centered approach, ensuring all necessary care for the whole child is received, not only for the CCS condition.

In the WCM, CenCal Health is responsible for Neonatal Intensive Care Unit (NICU) criteria assessment, High-Risk Infant Follow-Up (HRIF), criteria assessment, authorization for services, and case management. The WCM program provides medical case management and care coordination to eligible children. Services offered include diagnostic exams, medical treatment, transportation assistance, and physical and occupational therapies. CCS members are assigned to a PCP who is CCS paneled and contracted with CenCal Health. Methods to ensure timely access may include member assignment to a specialist as a PCP. In such cases, the specialist would be required to fulfill the responsibilities and contractual requirements of a PCP, including completion of the Facility Site Review.

CCS counties are responsible for determining CCS eligibility and paneling of CCS providers. Examples of CCS-eligible medical conditions include, but are not limited to, cystic fibrosis, sickle cell disease, hemophilia, cerebral palsy, heart disease, cancer, and traumatic injuries.

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

CCS Eligibility

The CCS program delivers specialized services to financially and medically eligible children under the age of 21 who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations.

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

Referrals

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

Authorizations

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

CCS Eligibility Annual Renewals

CCS eligibility will be reviewed by the CCS counties on an annual basis. CCS providers must send the most recent clinic visit notes and medical records to CenCal Health following the appointment to ensure that authorizations to CCS specialists or specialty care centers are renewed timely.

Pediatric Whole Child Model

The Pediatric Whole Child Program has dedicated nurses, social workers, and nonclinical professionals who assist providers with the timely processing of necessary specialty referrals and service requests, as well as provide care coordination and care transition services to members. The Pediatric Program is designed as a "one-stop shop" for providers to obtain covered services for children and youth under the age of 21. The Pediatric team is comprised of a group of specialized staff who perform both utilization review and case management activities. Like CenCal Health's Adult Case Management Program, pediatric care coordination and care transition services are dependent on active family and/or caregiver participation.

The Pediatric team processes, facilitates, and/or coordinates:

- Referrals (RAF).
- Prior authorization requests (50-1, 18-1, 20-1).
- Care management and coordination of healthcare services or with specialized programs, such as CCS, TCRC, LEA, etc.
- Care transition from one setting to another.
- Individualized (or family) guidance, education, community resources.
- Transition planning to adulthood.

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

Reference Links:

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

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

CenCal Health's Referral Authorization Form (RAF) Exceptions List
www.cencalhealth.org/wp-content/uploads/2024/12/202104rafexceptionslist-tagged.pdf

California Children's Services Whole Child Model Program
APL 24-015
www.dhcs.ca.gov/wp-content/uploads/2025/10/APL24-015.pdf

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E19: Community-Based Adult Services (CBAS)

CBAS is a benefit available to eligible Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care and CenCal CareConnect members. Eligibility to participate in CBAS is determined by CenCal Health and CenCal CareConnect.

CBAS centers offer therapeutic and social services in a community-based day healthcare program. Services are provided according to a six-month plan of care developed by the CBAS center's multidisciplinary team and CenCal Health's Health Services team. The services are designed to prevent early and unnecessary institutionalization and to keep recipients as independent as possible in the community.

CBAS services include:

- An individual assessment
- Professional nursing services
- Physical, occupational, and speech therapies
- Mental health services
- Therapeutic activities
- Social services
- Personal care
- Meals
- Nutritional counseling
- Transportation to and from the participant's residence and the CBAS center

Billing Codes and Reimbursement Rates:

The billable reimbursement rate is determined by the date of service.

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

Authorization:

CBAS initial assessment and transition days do not require prior authorization of a Treatment Authorization Request (TAR). CBAS regular days of attendance require a TAR. Please refer to Section H of the Provider Manual.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E20: Palliative Care

Description of Palliative Care Benefits

Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The benefit includes access to a multidisciplinary care team that coordinates and supports the member's advance care planning and their medical, pain, and symptom management, and mental, emotional, and spiritual care coordination needs. Palliative care is delivered predominantly on an outpatient basis; however, the benefit is available to members at an inpatient facility.

Palliative care does not require the member to have a life expectancy of six months or less and may be provided concurrently with curative/regular care. The provision of palliative care shall not result in the elimination or reduction of any covered services or benefits and shall not affect a member's eligibility to receive any services, including home health services, for which the member may not have been eligible in the absence of receiving palliative care.

Member Eligibility Criteria for Palliative Care

Palliative care is available to adult and pediatric members. The palliative care benefit shall apply to CenCal Health and CenCal CareConnect members. A member who is receiving palliative care may choose to transition to hospice care if they meet the hospice eligibility criteria. Members may not be concurrently enrolled in hospice care and palliative care.

Member eligibility for palliative care services includes the minimum criteria as set by the DHCS All Plan Letter (APL) 18-020 or successor policy.

*A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Patient Protection and Affordable Care Act Section 2302, as detailed in CMS Letter #10-018.

Pediatric palliative care eligibility criteria include the following:

- The family and/or legal guardian agree to the provision of pediatric palliative care services; and
- There is documentation of a life-threatening diagnosis. This can include, but is not limited to:
    - Conditions for which curative treatment is possible but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or

- Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
- Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
- Conditions involving severe, non-progressive disability or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

*Not applicable to CenCal CareConnect members.

In addition to the state minimum criteria for adult members (21 years and older), CenCal Health eligibility criteria for CenCal Health palliative care will also include the following:

- Members with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), cancer, or liver disease who may not meet the disease specifications set by DHCS, but who are clinically deteriorating and whose death within a year would not be unexpected based on clinical status.
- Members who meet DHCS criteria, but who still have reservations about participating in Advance Care Planning or foregoing emergency room treatment.
- Members who have other advanced or progressive illnesses whose death within a year would not be unexpected based on clinical status. Included illnesses are advanced ALS, multiple sclerosis, interstitial lung disease, primary pulmonary hypertension, HIV/AIDS, and end-stage rheumatologic illnesses.
- The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
- Illnesses not indicated above may be considered on a case-by-case basis with approval from a CenCal Health medical director.

Medical records should be available for any member upon request from CenCal Health to determine eligibility for the benefit.

Authorization Requirements for Palliative Care Program Benefit

A TAR (Treatment Authorization Request)/Prior authorization request for initial palliative care assessments and consultations is auto-approved. It includes a seven-day global period for services rendered while exploring the benefit. The request may be submitted by a member's PCP, specialist, or a contracted CenCal Health palliative care provider. It is recommended to submit supporting documentation, particularly for members under the age of 21. Members may contact CenCal Health directly to self-refer for services. There is an add-on payment for the completion of a POLST (Physician Orders for Life Sustaining Treatment) form.

After completion of the initial assessment and consultation, and the member has decided to participate in the palliative care program, a TAR/Prior Authorization request is required to commence ongoing palliative care program services. A TAR/Prior Authorization request will be required for every subsequent six months (up to 12 units, where each unit is a two-week global period) of palliative care program services, re-certifying the member's qualifying condition along with an updated Plan of Care and/or recent progress notes.

Palliative care providers must maintain appropriate medical records documenting all services rendered to members and submit palliative care utilization data and other records as required by CenCal Health to substantiate the services rendered.

You can access the Palliative Care Provider Training online at www.cencalhealth.org/providers/provider-training-resources/provider-training-library/.

Consideration for Prospective Providers of Palliative Care

Provider organizations should meet the following criteria to be considered for a contract with CenCal Health for palliative care program services:

- Organization and all providers and subcontractors are enrolled Medi-Cal and/or Medicare providers.
- Clinical staff are trained in palliative care from an appropriate credentialing or oversight organization.
- Medical director must have specialized and current palliative care training and/or certification as a palliative care physician.
- 24/7 telephonic care with access to a nurse who has access to the member's medical record and Plan of Care to assist with informed decision-making.
- Ability to collect and submit all required clinical, encounter, and quality data as required by CenCal Health.
- Core staffing identified in a roster to include, at minimum, a medical director, registered nurse(s), social worker(s), and administrator with:
    - Palliative care training and/or certification obtained to date, and/or any future training/certification planned.
    - *Pediatric training and/or certification for providers able to offer palliative care services to pediatric members (under the age of 21) for staff who would render services to pediatric members, appropriate to their scope of services.
- If the organization will contract for some of these services, please describe the contractual arrangements.
- If the organization is not a hospice and/or home health organization, submission of a letter or Memorandum of Understanding (MOU) with a local hospice and/or home health organization(s) that can accept patients who need those services is required.

***Pediatric Services are excluded for CenCal CareConnect members.**

Reference Links:

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

Department of Health Care Services, Palliative Care All Plan Letter
APL 18-020
www.dhcs.ca.gov/wp-content/uploads/2025/10/APL18-020.pdf

This section applies to the following CenCal Health programs:

Medi-Cal

E21: Diabetes Prevention Program

Description of Diabetes Prevention Program

A diabetes prevention program (DPP) is an evidence-based lifestyle change program taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. The Centers for Disease Control and Prevention (CDC) established the National DPP and set national standards and guidelines, also known as the CDC Diabetes Prevention Recognition Program (DPRP), for the effective delivery of the national DPP lifestyle change program.

Provider Requirements for DPP Agreement with CenCal Health

Provider organizations must be actively certified by the CDC as a recognized DPP program in connection with the DPRP program and Medi-Cal DPP standards. Providers who are in the process of obtaining CDC DPP certification may contact CenCal Health to initiate the contracting process.

Members must be screened per CDC guidelines to ensure they meet CDC DPRP participant eligibility for the benefit. Peer coaches and lifestyle coaches rendering for the provider organization must be specially trained to administer the DPP curriculum in accordance with the CDC DPRP program guidelines. Providers must maintain adequate documentation of all services, including program milestones (when met), and must furnish any documentation required by CenCal Health to substantiate the services billed.

Due to the serial nature of DPP coursework, providers must offer a new series of DPP courses within their service area at least quarterly to ensure adequate access to the benefit for members.

Authorization Requirements for DPP Program Benefit

A RAF from a member's PCP is required by CenCal Health for payment of any DPP program services. Referral providers and case managers can direct members to contact their PCP for a referral to the CenCal Health contracted DPP provider. A

contract for DPP services is required to be eligible to receive a RAF for DPP services. Providers should refer to the Medi-Cal State Manual and state website for details on coding and billing for services.

This section applies to the following CenCal Health programs:

Medi-Cal

E22: Blood Lead Level Testing in Children

Lead screening and testing in children is a required preventive service under Medi-Cal's EPSDT benefit, supports early identification of environmental health risks, prevents adverse developmental outcomes, advances health equity objectives, and serves as an important measure of pediatric preventive care quality.

All providers who perform periodic health assessments on members between the ages of 6 months and 6 years (72 months) must ensure children are tested for blood lead levels (BLL) **at both 12 months and 24 months of age, and order catch-up testing if missed at either 12 or 24 months**. Federal law requires the testing of children enrolled in Medicaid for elevated blood lead levels as part of required preventive services offered through Medi-Cal for Kids & Teens, formerly known as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. CenCal Health covers this test in accordance with the California Code of Regulations (CCR) to comply with federal and state law.

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

Providers Responsibilities:

- Conduct a risk assessment at each PHA, starting at 6 months of age and continuing until 72 months of age, to identify environmental or behavioral factors that increase a child's risk of lead exposure. Document the risk assessment in the medical record.
- Perform blood lead tests at 12 and 24 months, and order catch-up testing if missed at these ages. If point-of-care testing is not available at your practice, document the lead test order.
- Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.
    - This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.

- Document blood lead screening guidance, test date, and results in the child's medical record.
- If the parent(s) or guardian(s) of a child member refuse the blood lead testing, providers must include a signed statement of voluntary refusal by the member (if an emancipated minor) or the parent(s) or guardian(s) of the member in the child's medical record. If a signed statement is unable to be obtained, the provider must document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record.
    - A refusal form template is provided on the CenCal Health website.
- Follow the Centers for Disease Control and Prevention (CDC) requirements for Post-Arrival Lead Screening of Refugees, contained in the CLPPB-issued guidelines.

Monitoring

Through the DHCS-required Facility Site Review (FSR) process, CenCal Health verifies that applicable contracted providers reliably report required blood lead test results to CLPPB. Additionally, through a year-round Medical Record Review (MRR) Program, CenCal Health verifies that applicable contracted providers appropriately conduct risk assessments and test for lead exposure.

CenCal Health reports to DHCS the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday as part of the defined set of performance measures that all Medi-Cal managed care plans are required to report, known as the Medi-Cal Managed Care Accountability Set (MCAS). See Section L5: Performance Monitoring for additional details.

Provider Reports

On a monthly basis, CenCal Health monitors the prevalence and timeliness of blood lead testing in its membership, using the prevailing industry-standard methodology. CenCal Health identifies members less than 6 years of age with no record of receiving a required lead test and notifies providers via an opportunity report found on the Provider Portal.

CenCal Health's Quality Care Incentive Program (QCIP)

Given the importance of lead screening and testing, lead testing is one of the priority measures in CenCal Health's Quality Care Incentive Program (QCIP). These reports are available within the QCIP section of the Provider Portal.

Billing

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

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

Reference Links:

Bright Futures/AAP Periodicity Schedule

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

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

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

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

CenCal Health Provider Portal
https://web.cencalhealth.org/Account/Login
DHCS All Plan Letter 20-016: Blood Lead Screening of Young Children (Supersedes APL18-017)
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf

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

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

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E23: Doula Services

CenCal Health covers doula services, which include health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

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

Non-Covered Services

Doula services that are not covered under Medi-Cal include:

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

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

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

To be eligible for credentialing, contracting, and participation in the CenCal Health provider network, doulas must meet applicable DHCS qualification requirements, maintain active Medi-Cal enrollment through the DHCS Provider Application and Validation for Enrollment (PAVE) process, satisfy CenCal Health credentialing and onboarding requirements, and enter into a contractual agreement with CenCal Health. Doulas must meet the following minimum requirements and qualify through either the Training Pathway or Experience Pathway:

- Be at least 18 years old.
- Provide proof of an adult/infant cardiopulmonary resuscitation (i.e., CPR) certification from the American Red Cross or American Heart Association.
- Attest to have completed basic Health Insurance Portability and Accountability Act (HIPAA) training.
- Have a National Provider Identifier (NPI) number (request one at

https://nppes.cms.hhs.gov).

Doulas must meet qualification either through the Training or Experience Pathway, as follows:

- **Training Pathway:**
  - Certificate of completion for a minimum of 16 hours of training in the following topics:
    - Lactation support.
    - Childbirth education.
    - Foundations on the anatomy of pregnancy and childbirth.
    - Nonmedical comfort measures, prenatal support, and labor support techniques.
    - Developing a community resource list.
  - Attest that they have provided support at a minimum of three births as a doula.
- **Experience Pathway:**
  - Attest that they have provided services in the capacity of a doula, either in a paid or volunteer capacity, for at least five years. The five years of experience in the capacity of a doula must have occurred within the previous seven years.
  - Attestation to skills in prenatal, labor, and postpartum care as demonstrated by the following:
    - Three written client testimonial letters or professional letters of recommendation from the past seven years. Professional letters from any of the following are acceptable: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven years. **One letter must be from either a licensed provider, a community-based organization, or a DHCS-enrolled doula.**

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

Covered Services

Any licensed practitioner may make recommendations for doula services by completing a Doula Services Recommendation Form, which can be found on the CenCal Health website: https://form.cencalhealth.org/DOULA/DOULA. The following covered services are automatically approved by CenCal Health (visits are limited to one per day, per member):

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

- Additional recommendations can include up to nine additional one-hour postpartum visits.

One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. Only one doula can bill for a visit provided to the same member on the same day, excluding labor and delivery. The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different doula. The extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation. The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual, provided on separate days.

Doula Service Documentation Requirements
Doula service providers are required to document the dates and time/duration of services provided to CenCal Health members, which should also reflect information on the nature of the care and service(s) provided to support the length of time spent with the member that day. (For example, documentation might state, "Discussed childbirth education with the beneficiary and discussed and developed a birth plan for one hour."). Documentation must be accessible to CenCal Health and DHCS upon request.

Doula Service Billing Code Details
Contracted doula providers may use the following codes for services listed here when submitting claims to CenCal Health.

ICD-10-CM Diagnosis Codes
One of the ICD-10-CM diagnosis codes below is required when billing for doula services under Medi-Cal in both fee-for-service and managed care:

- Z32.2 - Encounter for childbirth instruction
- Z32.3 - Encounter for childcare instruction
- Z33.1 - Pregnant state, incidental
- Z39.0 - Encounter for care and examination of mother immediately after delivery
- Z39.1 - Encounter for care and examination of lactating mother
- Z39.2 - Encounter for routine postpartum follow-up

Note: These ICD-10-CM diagnosis codes are only used by doulas to describe what occurred during the service billed with the CPT/HCPCS codes below. They are not being used for medical and/or diagnostic purposes.

For each listed doula service CPT or HCPCS code, at least one of the required ICD-10-CM diagnosis codes must be used:

Table of CPT/HCPCS Codes and Required ICD-10-CM Codes	
CPT/HCPCS Code(s)	**Required ICD-10-CM Code(s)**
Z1032	Z32.2, Z32.3, Z39.1, Z39.2
Z1034	Z32.2, Z32.3
59409, 59612, 59620	Z33.1, Z39.0

59840, T1033	Z33.1
T1032, Z1038	Z39.0, Z39.1, Z39.2

Prenatal and Postpartum Visits

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

Note: Extended initial visit must be for 90 minutes to bill with Z1032-XP

Labor and Delivery Support

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

Abortion or Miscarriage Support

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

NOTE: All claims must be submitted with the modifier XP (separate practitioner: a service that is distinct because it was performed by a different practitioner), appended to the billing code. This is to distinguish the claim from the services by the medical provider.

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

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

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

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

Reference Links:
Onboarding Packet

www.cencalhealth.org/providers/join-our-network/credentialing-applications-and-forms/
https://www.cencalhealth.org/providers/social-determinants-of-health/
Doula All Plan Letter 23-024
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL-23-024.pdf

Doula Services Recommendation Form
https://form.cencalhealth.org/DOULA/DOULA

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E24: Community Health Worker Services

Community Health Worker (CHW) services became a Medi-Cal benefit on July 1, 2022. CHW services are preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by various job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. Importantly, CHW services provide a mechanism for delivering equitable and culturally competent care for CenCal Health members, which aligns with CenCal Health's Population Health Management program.

Covered Services
CenCal Health covers CHW services for members who meet criteria in accordance with CenCal Health policy and DHCS requirements, which include:

- Preventive health services to prevent disease, disability, and other health conditions or their progression to help prolong life and promote physical and mental health.
- Screening and assessment not requiring a license and assisting a beneficiary in connecting to appropriate services to improve their health.
- Individual support or advocacy to assist a beneficiary in preventing the onset or exacerbation of a health condition, preventing injury, or violence.
- Asthma preventive services for individuals with asthma, but evidence-based asthma self-management education and asthma trigger assessments may only be provided by asthma preventive service providers who have completed a certificate from the California Department of Public Health Asthma Management Academy.
- Services may also address issues that include, but are not limited to:
    - Control and prevention of chronic conditions or infectious diseases.
    - Mental health conditions and substance use disorders.
    - Need for preventive services.
    - Perinatal health conditions.

    - Sexual and reproductive health.
    - Environmental and climate-sensitive health issues.
    - Child health and development.
    - Oral health.
    - Aging.
    - Health education to promote the beneficiary's health or address barriers to physical and mental health care, including providing information or instruction on health topics.
    - Health navigation to provide information, training, referrals, or support to assist beneficiaries to:
        - Access health care.
        - Understand the health care system.
        - Engage in their own care.
        - Connect to community resources necessary to promote a beneficiary's health.
        - Address health care barriers, including connecting to medical translation/interpretation or transportation services.
        - Address health-related social needs.

Health education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a beneficiary's health or ability to self-manage health conditions.

- **CHW Violence Preventive Services**
    - Evidence-based, trauma-informed, and culturally responsive preventive services provided by an individual qualified through any of the pathways listed below for the purpose of reducing the incidence of domestic violence, violent injury or reinjury, trauma, and related harms and promoting trauma recovery, stabilization, and improved health outcomes.
    - Violence prevention services may be provided to a parent or legal guardian of a CenCal Health member under the age of 21 for the direct benefit of the beneficiary, in accordance with a recommendation from a licensed provider.
- Services for the direct benefit of the CenCal Health member must be billed under the beneficiary's Medi-Cal ID.
- Services are covered by Medi-Cal as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law.

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

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

- The presence or risk of one or more chronic conditions or environmental health exposure;

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

Additional details regarding member eligibility for CHW services can be found in DHCS All Plan Letter 24-006: APL24-006.

Servicing Provider
Individuals providing CHW services, and the supervising providers or organizations with which they are affiliated, must comply with applicable DHCS qualification requirements and CenCal Health participation requirements. As part of network participation, supervising providers and organizations participating in the CHW program must maintain policies, procedures, and operational processes sufficient to demonstrate compliance with applicable DHCS and CenCal Health program requirements. Those requirements include:

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

Supervising providers or organizations must verify and maintain documentation supporting CHW qualifications through the Professional Certification Pathway or Work Experience Pathway before authorizing a CHW to provide services to CenCal Health members.

Formal CHW certification, if not present, is required within 18 months of providing the first CHW service to a CenCal Health member. Additionally, all CHWs are required to complete an annual requirement of six hours of ongoing training.

All CHWs must be supervised by an organization or provider who is responsible for ensuring compliance with applicable DHCS qualification, certification, training, supervision, and continuing education requirements. The supervising provider or organization is responsible for maintaining documentation demonstrating compliance with these requirements, retaining such documentation in accordance with applicable legal and regulatory requirements, and making such documentation available to CenCal Health upon request.

Program Oversight Requirements
Supervising providers and organizations participating in the CenCal Health CHW program must maintain processes to verify CHW qualifications, required training and continuing education, applicable certifications, supervision, and compliance with DHCS requirements. CenCal Health may review policies, procedures, rosters, attestations, qualification records, training records, supervision documentation, and other supporting materials during onboarding, credentialing, contracting, oversight, monitoring, auditing, or other compliance activities, and may require corrective action

or additional documentation to address identified compliance deficiencies. CenCal Health's review of supporting documentation does not relieve supervising providers or organizations of their responsibility to maintain ongoing compliance with applicable DHCS, Medi-Cal, and CenCal Health requirements.

Lived Experience Requirements

- CHWs must have lived experience that aligns with and provides a connection between the CHW and the community or population being served.
- This may include, but is not limited to, lived experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation.
- Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background of one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

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

Professional Certification Pathway Requirements

A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement.

Work Experience Pathway Requirements

An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the supervising provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a member.

Violence Prevention Professional (VPP)

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

Supervising Providers
Where a DHCS enrollment pathway exists, the supervising provider shall maintain active Medi-Cal enrollment and be responsible for submitting claims, ensuring CHW qualification and compliance, and providing direct or indirect oversight of CHW services delivered to Medi-Cal beneficiaries. A supervising provider can be a licensed provider, a hospital, an outpatient clinic, a Local Health Jurisdiction (LHJ), or a Community-Based Organization (CBO).

Supervising providers and organizations must maintain policies, procedures, and operational processes that support oversight of CHWs, including qualification review, training, supervision, documentation, and compliance with applicable DHCS requirements.

Supervising providers can provide supervision, coaching, direct support, and leadership to CHWs through training, mentoring, and case conferencing. CHWs can be supervised by a CBO or LHJ without a licensed provider on staff. They do not need to be the same entity as the provider who made the written recommendation for CHW services, and they do not need to be physically present at the location when CHWs provide services to the CenCal Health member.

Management and day-to-day supervision of CHWs:

The supervising provider does not need to be the same entity as the provider who made the referral for CHW services. Supervising providers do not need to be physically present at the location when CHWs provide services to members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the supervising provider. However, the supervising provider is responsible for ensuring the provision of CHW services complies with all applicable requirements. Supervising providers must provide direct or indirect oversight to CHWs. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of a plan of care, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.

Eligibility Criteria for Services
CHW services require a written recommendation submitted to CenCal Health by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a network provider within the member's MCP or employed by the supervising provider. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

The recommending licensed provider must ensure that a member meets eligibility criteria before recommending CHW services. CHW services are considered medically necessary for members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services. The recommending provider must determine whether a member meets eligibility criteria for CHW services based on the presence of one or more of the following:

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

Documentation Requirements

CHWs are required to document the dates and time/duration of services provided to members. Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient that day. For example, documentation might state, "Discussed the patient's challenges accessing healthy food and options to improve the situation for 15 minutes. Assisted with the Supplemental Nutrition Assistance Program application for 30 minutes. Referred patient to [XYZ] food pantry." Documentation must be accessible to the supervising provider upon their request. Documentation should be integrated into the member's medical record and available for encounter data reporting.

Plan of Care

For members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan must be written by one or more individual licensed providers, with the exception of services provided in the emergency department, which may include the

recommending provider and other licensed providers affiliated with the CHW supervising provider. The provider ordering the plan of care does not need to be the same provider who initially recommended CHW services or the supervising provider for CHW services. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the member's care team and/or other providers referenced in this section. The plan of care may not exceed a period of one year. The plan of care must:

- Specify the condition that the service is being ordered for, and its relevance to the condition;
- Include a list of other health care professionals providing treatment for the condition or barrier;
- Contain written objectives that specifically address the recipient's condition or barrier affecting their health;
- List the specific services required for meeting the written objectives; and
- Include the frequency and duration of CHW services (not to exceed the provider's order) to be provided to meet the plan's objectives.

A licensed provider must review the member's plan of care at least every six months from the effective date of the initial plan of care. The licensed provider must determine if progress is being made toward the written objective and whether services are still medically necessary. If there is a significant change in the recipient's condition, providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

Recommendation Requirements
CHW rendered services are recognized in 30-minute units, and the first 12 units (six hours) are auto-approved via the CHW Recommendation Form platform on the CenCal Health website. For requests beyond the initial 12 units, a Treatment Authorization Request (TAR)/Prior Authorization request and a written Plan of Care are required and must be submitted to CenCal Health. See **Plan of Care** section. Additional information regarding the provision of CHW services can be found in CenCal Health's Community Health Worker policy, available to providers upon request.

CenCal CareConnect Care Management CHW Support
CenCal CareConnect members may also receive Community Health Worker (CHW) support through the Care Management team to assist with accessing supplemental benefits, community resources, and services that support health-related social needs.

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

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

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

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

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

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

CPT Code with modifier	Time with Member	Patient Numbers
98960 with modifier U2*	30 minutes	1
98961 with modifier U2*	30 minutes	2-4
98962 with modifier U2*	30 minutes	5-8

*Modifier U2 required to denote services rendered by Community Health Workers.

In addition to the three CPT codes listed above and billed with modifier U2 for CHW services, the following Healthcare Common Procedure Coding System (HCPCS) codes may also be used for covered CHW services by the supervising provider.

HCPCS G0019 must be billed with modifier U2: Community Health Integration (CHI) services performed by certified or trained auxiliary personnel, included a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit:

- Person-centered assessment, performed to better understand the individual context of the intersection between the SDOH need(s) and the problems addressed in the initiating visit.
- Practitioner, home, and community-based care coordination.
- Facilitating access to community-based social services to address SDOH need(s).
- Health education, such as helping the patient contextualize health education provided by the patient's treatment with the patient's individual needs, goals and preferences, and educating on how to best participate in medical decision-making.
- Building patient self-advocacy skills, so that the patient can interact with the healthcare team.
- See the pages of the Medi-Cal Manual under (chw prev) for additional service descriptions.

CHW supervising providers can bill for additional CHI services with HCPCS code G0022, billed with modifier U2, and must be listed separately in addition to G0019.

HCPCS code G0019 maximum frequency is one unit (60 minutes) per calendar month, per member, any provider. It cannot be billed during the same calendar month as CPT 98960 by the same provider.

HCPCS code G0022 maximum frequency is four units (two hours) per calendar month, per member, per provider. Additional units per month may be provided with an approved TAR for medical necessity. TARs may be submitted after the service is provided.

Additional Billing Instructions for HCPCS codes G0019 and G0022

All claims for HCPCS code G0019 must be billed after a licensed Medi-Cal provider identifies an unmet SDOH need during an initiating visit that significantly limits their ability to diagnose or treat the member. The initiating visit must occur during the preceding six months prior to the claim for HCPCS code G0019, and the initiating visit must be billed with one of the following:

- Office or other outpatient services: CPT codes 99203 through 99205 and 99213 through 99215
- Home or residence services: CPT codes 99342, 99344 through 99345, and 99348 through 99340
- Preventive medicine services: CPT codes 99381 through 99387 and 99391 through 99396

Following the initiating visit, a licensed Medi-Cal provider must:

- Identify an unmet SDOH need that significantly limits their ability to diagnose or treat the member and,
- Develop a treatment plan that includes the ICD-10-CM diagnosis code(s) and share the treatment plan with the CHW's supervising provider, who will bill HCPCS codes G0019, and when applicable, G0022 for the subsequent CHW services provider.

Note: A CHW may also draft a treatment plan that identifies interventions for CHW services, which is then reviewed and approved by a licensed provider who may be a different licensed provider than the one who performed the initiating visit and is also shared with the CHW's supervising provider and licensed provider of the initiating visit, as described in more detail in this policy.

All billed claims for HCPCS code G0019 must include at least one of the following ICD-10-CM diagnosis code(s), Z55-Z65, which should also be identified in the treatment plan for services to be billed with HCPCS codes G0019, and when applicable, G0022 following the initiating visit:

ICD-10-CM Diagnosis Code	Description
Z55	Problems related to employment and unemployment
Z56	Problems related to education and literacy
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances

Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

In addition, the Medi-Cal provider for the initiating visit must ensure that the following is documented in the member's medical record and available to DHCS upon request:

- The SDOH need(s) intended to be addressed, and clinical problem(s) intended to be resolved. Documenting ICD-10-CM code(s) listed above can count as appropriate documentation.
- The specific CHW-covered services to be performed by the CHW.

All claims for G0022 must be billed on or after the initial billing for the date of service of HCPCS code G0019, which also follows the initiating visit with the licensed Medi-Cal provider billed within the preceding six months. If a licensed provider determines that SDOH need(s) change after the initiating visit, then the new SDOH need(s) and corresponding ICD-10-CM diagnosis code(s) must be used on the corresponding claim for HCPCS code G0022.

Telehealth Modalities

Covered CHW services may be provided via synchronous telehealth modalities when it is appropriate to do so and consistent with Medi-Cal policy. Synchronous telehealth modalities are real-time, two-way interactions between a member and a health care provider in which services are rendered using audio-visual technology or audio-only in limited circumstances outlined in Medi-Cal policy. CHWs may not provide asynchronous telehealth modalities, including store and forward or e-consult.

- Modifier 95 – interactive audio and video communication where the patient and the CHW provider see and hear each other.
- Modifier 93 – real-time audio-only interaction conducted via telephone without any visual or video equipment. To be used only when video is unavailable, unfeasible, or declined by the patient.
- Modifier 95 and 93 MUST be used in conjunction with modifier U2 for CHW billed claims.

Community-Based Organizations (CBOs) and Local Health Jurisdictions (LHJs) providers must use modifier U2 with the above HCPCS and CPT codes to denote services rendered by community health workers. Other supervising providers should use modifier U2 with the above CPT codes to denote services rendered by community health workers.

Reference Links:

DHCS All Plan Letter (APL 24-006)
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-006.pdf

CHW Medi-Cal Manual
Community Health Worker (CHW) Preventive Services (chw prev)
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/03BBA223-8762-4A94-A268-209510E15E37/chwprev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

E25: Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older

CenCal Health members who are 65 years of age or older and who do not have Medicare coverage may obtain an annual cognitive health assessment.

For members under 65 years of age who are reporting symptoms or showing signs of cognitive decline, CenCal Health will continue to require medically necessary and appropriate coverage of assessments, which may include, but are not limited to:

a) Cognitive health assessments,
b) Appropriate treatment services, and
c) Necessary referrals, billed through established practices.

Medicare beneficiaries are eligible for cognitive screening(s) through the Medicare Annual Wellness Visit. Providers are advised to follow the dementia assessment requirements outlined in the D-SNP Policy Guide and must continue to comply with all applicable D-SNP dementia assessment requirements.

Training and Certification
Training is no longer required for reimbursement or provision of the assessment effective as of June 30, 2025. However, providers may still utilize Dementia Care Aware resources, which can be found here: www.dementiacareaware.org

Billing and Payment
Providers must administer the annual cognitive health assessment as a component of an Evaluation & Management visit, including but not limited to, an office visit, consultation, or preventive medicine service.

Network providers must document all the following in the member's medical records and have such records available upon request:

- The screening tool or tools that were used.
- Verification that the screening results were reviewed by the network provider.
- The results of the screening.
- The interpretation of the results.

- Details discussed with the member and/or authorized representative, and any appropriate actions taken regarding screening results.

Details regarding billing codes, quantities, and rates can be found in the DHCS Medi-Cal Provider Manual.

Cognitive Assessment Tools
DHCS requires network providers to use at least one of the following approved cognitive assessment tools. The assessment needs to be completed by either health plan staff (including case managers and nurses) or providers. An informant (family member or friend) may assist by using an informant tool. Additionally, the patient's Activities of Daily Living and Instrumental Activities of Daily Living should also be reviewed and documented in the medical records as part of the assessment.

- Patient assessment tools approved by DHCS:
  - General Practitioner assessment of Cognition (GPCOG)
  - Mini-Cog
- Informant tools (family members and close friends)
  - AD8: Eight-item informant Interview to Differentiate Aging and Dementia
  - GPCOG
  - Short Informant Questionnaire on Cognitive Decline in the Elderly

Reference Links:
Additional details can be found in APL 26-014:
www.dhcs.ca.gov/wp-content/uploads/2026/07/APL26-014_d4abe7.pdf

Medicare Claims Processing Manual
www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf

The Medi-Cal Provider Manual, E&M, Cognitive Health Assessment
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/5EF3476E-5DF4-4512-822F-22660D31FA4B/eval.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

Additional resources:
www.dementiacareaware.org

This section applies to the following CenCal Health programs:

CenCal CareConnect (HMO D-SNP)

E26: Supplemental Benefits – CenCal CareConnect

CenCal Health offers additional benefits, called supplemental benefits, to members who are covered by CenCal CareConnect. These benefits go beyond what's typically

covered by Medicare and include:

Vision Supplemental Benefit

This benefit includes one routine vision exam per year and up to $400 every two rolling years for eyeglasses (frames and lenses) or contact lenses. No prior authorization is required to access vision services; however, members must use an in-network vision provider. Please refer to the CenCal CareConnect Provider Directory to find a participating optometrist or optician who is contracted to provide this benefit. If the cost of eyewear exceeds the benefit allowance, a member will be responsible for the difference or may leverage their standard Medi-Cal vision benefits, if eligible.

For contracted CenCal CareConnect Providers, the eligible CPT codes and rates include:

SERVICE DESCRIPTION	APPLICABLE CODE(S)	REIMBURSEMENT RATE
Eye Exam, New or Established Patient	92002, 92004, 92012, 92014	100% Medicare Fee Schedule
Special Ophthalmological Services	92015	$8.01
Contact Lens Services	92310	$56.67
Special Ophthalmological Services	92072	100% Medicare Fee Schedule
Contact Lens Services	92311, 92312, 92313, 92326	100% Medicare Fee Schedule
Frames and Lenses	V2020, V2025 V2100-V2199 V2200-V2299 V2300-V2399 V2410-V2499 V2500-V2599 V2630-V2632 V2700-V2797	100% billed charges (to equate to retail price plus applicable sales tax), not to exceed $400.00 per CenCal CareConnect member every two rolling years for any combination of lenses and/or frames.
Miscellaneous Vision Service	V2799	Add Code at Pay, Up To: $126.46

Medical services covered by Medicare are subject to authorization requirements and do not count towards a DSNP member's Vision Supplemental Benefit maximum.

Hearing Exams and Hearing Aid Supplemental Benefit

This supplemental benefit includes one routine hearing exam per year and coverage for hearing aids for both ears, up to a total of $650 annually, in addition to the Medi-Cal $1,510 annual benefit limit. To use this benefit, members must visit an in-network hearing provider. If the total cost of the hearing aids exceeds the annual allowance, members will be responsible for the difference or may leverage their standard Medi-Cal hearing benefits. Please refer to the Provider Directory to find a participating audiologist or hearing aid vendor who is contracted to provide this benefit.

For contracted CenCal CareConnect providers, the eligible CPT codes and rates

include:

SERVICE DESCRIPTION	APPLICABLE CODE(S)	REIMBURSEMENT RATE
Audiologic Function Test; Service	92551	$12.67
Evaluative and Therapeutic Services; Service	92628	$97.47
Evaluative and Therapeutic Services; Service (each additional 15 minutes)	92629	$73.11
Evaluative and Therapeutic Services; Service	92631	$169.75
Evaluative and Therapeutic Services; Service (each additional 15 minutes)	92632	$127.32
Evaluative and Therapeutic Services; Service	92634	$56.98
Evaluative and Therapeutic Services; Service (each additional 15 minutes)	92635	$42.73
Evaluative and Therapeutic Services; Service	92636	$56.98
Evaluative and Therapeutic Services; Service (each additional 15 minutes)	92637	$32.87
Evaluative and Therapeutic Services; Service	92638	$118.26
Evaluative and Therapeutic Services; Service	92639	$118.26
Evaluative and Therapeutic Services; Service	92641	$91.76
Evaluative and Therapeutic Services; Service	92642	$91.76
Hearing Assessments and Evaluations; Service	V5008	$23.49
Hearing Assessments and Evaluations; Service	V5010	$57.70

Hearing Assessments and Evaluations; Service	V5011	$82.76
Hearing Assessments and Evaluations; Service	V5014	$35.86
Hearing Assessments and Evaluations; Service	V5020	$33.02
Audiologic Function Tests; Services	92550, 92552-92584, 92587, 92588, 92651-92653	Use 100% Medicare Fee Schedule
Evaluative and Therapeutic services, Services	92601-92604, 92620, 92625-92626	Use 100% Medicare Fee Schedule
Evaluative and Therapeutic services, Services (each additional 15 minutes)	92621, 92627	Use 100% Medicare Fee Schedule
Special Diagnostic Procedures, Service	92640	Use 100% Medicare Fee Schedule
Misc. Hearing Services and Supplies, Services	V5090, V5100, V5110	100% Billed Charges (to equate to retail price plus applicable sales tax), not to exceed $650.00 per CenCal CareConnect member per year.
Hearing Aid, Monaural Devices	V5030-V5060	100% Billed Charges (to equate to retail price plus applicable sales tax), not to exceed $650.00 per CenCal CareConnect member per year.
Hearing Aids, Devices	V5120-V5267	100% Billed Charges (to equate to retail price plus applicable sales tax), not to exceed $650.00 per CenCal CareConnect member per year.
Assistive Hearing Devices, Device	V5275	100% Billed Charges (to equate to retail price plus applicable sales tax), not to exceed the member benefit limit.

Services reimbursed based on the applicable Medicare fee schedule may be subject to the federal Medicare sequestration reduction (currently 2%). Services not reimbursed under a Medicare fee schedule are not subject to the Medicare sequestration reduction.

Over-the-Counter (OTC) Benefit

This benefit provides members with a $90 quarterly allowance to purchase approved OTC health items such as cold remedies, pain relievers, vitamins, first-aid supplies, and personal care products; no prior authorization is required. Unused funds do not roll over to the next quarter. Members may access this benefit using the Benefits Prepaid Card or by ordering eligible OTC items through the plan's approved catalog, online ordering portal, by phone, or at a contracted pharmacy/store. Items ordered will be shipped directly to the member's home at no additional cost. Please review the OTC catalog for a full list of covered items and ordering instructions.

The eligible items include, but are not limited to:

- Cold, allergy, and sinus remedies.
- Pain relief medications.
- Vitamins and supplements.
- First-aid supplies (bandages, antiseptics, etc.).
- Personal care products (oral care, skin care, etc.).

Section F: Services Covered by Other Agencies

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

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

F1: Dental Services for Medi-Cal Members

The Medi-Cal program covers some dental services, including:

- Diagnostic and preventive dental hygiene (such as examinations, X-rays, and teeth cleanings).
- Emergency care for pain control.
- Tooth extractions.
- Fillings.
- Root canal treatments (anterior/posterior).
- Crowns (prefabricated/laboratory).

- Scaling and root planning.
- Periodontal maintenance.
- Complete and partial dentures.
- Orthodontics for children who qualify for dental services requiring IV sedation or general anesthesia.
- Topical fluoride.

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

Most of these services are offered through the Medi-Cal Dental Program, not CenCal Health. If members have any questions, want to learn more about dental services or want to find a dentist in their area, call the Medi-Cal Dental Program at 1-800-322-6384 or (TTY: 1-800-735-2922 or 711). You may also visit the Medi-Cal Dental Program website at www.dental.dhcs.ca.gov or smilecalifornia.org.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

F2: Specialty Mental Health Services

Specialty Mental Health Services (SMHS) are provided through County Mental Health Plans (MHPs) for CenCal Health members who meet the criteria for specialty level of care. Services include:

- Individual, family, and group psychotherapy and rehabilitation services.
- Medication support services.
- Crisis intervention, stabilization, and residential services.
- Targeted case management services.
- Therapeutic behavioral services, intensive home-based services, intensive care coordination, and therapeutic foster care for members under the age of 21.
- Psychiatric consultation in the emergency department.
- Residential treatment, partial hospital treatment, or intensive outpatient services for mental health or eating disorders.
- Electroconvulsive therapy (ECT).

Referral

Members may access county specialty mental health and substance use disorder services directly. Members may also contact CenCal Health's Behavioral Health

Department for help with care coordination, service navigation, or connections to appropriate services.

CenCal Health Behavioral Health Department

- Member Line: 1-877-814-1861
- Provider Line: 805-562-1600
- Fax number: 805-681-3070

Santa Barbara County Department of Behavioral Wellness

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

San Luis Obispo Department of Behavioral Health

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

F3: County Substance Use Services

Substance use treatment is provided by the County Department's Drug Medi-Cal Organized Delivery System (DMC-ODC) to members who are identified as requiring alcohol and/or substance use disorder services. The county provides treatment of substance use disorders modeled after the American Society of Addiction Medicine (ASAM) criteria. Covered services include:

- Withdrawal management.
- Intensive outpatient and outpatient services.
- Opioid (narcotic) treatment programs.
- Recovery services.
- Case management.
- Perinatal and non-perinatal residential substance abuse services.
- Outpatient therapy or medication services for a primary substance-use diagnosis.
- Residential treatment/partial hospital treatment or intensive outpatient services for dual diagnosis, substance use disorders, or alcohol use disorders.

Referral

Members may be referred directly to county MHPs or may be referred to CenCal Health's Behavioral Health Department for coordination, if needed or requested by the member.

Santa Barbara County Department of Behavioral Wellness

- Access Line (24/7): 888-868-1649

San Luis Obispo Department of Behavioral Health

- Access Line (24/7): 800-838-1381

Reference Links:

Santa Barbara County Alcohol and Other Drugs Services
www.countyofsb.org/531/Alcohol-Other-Drugs

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

F4: Tri-Counties Regional Center

Tri-Counties Regional Center (TCRC) is one of 21 nonprofit regional centers in California, providing lifelong services and supports for people with developmental disabilities residing in San Luis Obispo, Santa Barbara, and Ventura counties.

TCRC operates two separate programs, each with different eligibility rules.

1. **Early Start Program**
   This program serves infants and toddlers from birth to 36 months who have, or are at risk for, developmental disabilities. Eligibility includes a developmental delay of 25% or more in one or more areas: social, adaptive, physical, cognitive, or expressive/receptive communication. Children may also qualify if a medical professional determines they are at risk due to factors such as low birth weight, prematurity (under 32 weeks), prenatal exposure to drugs or alcohol, significant birth injury, abuse or neglect, or if they have a condition known to cause developmental delays. Eligibility is not based on family income or immigration status. Services are based on the child's Individual Family Service Plan (IFSP) and may include a range of early intervention supports. Parents also have access to peer support through Family Resource Centers.

2. **General Services Program**
   This program serves individuals aged 3 and older with a qualifying disability that began before age 18, is expected to be lifelong, and results in a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, epilepsy, autism, and other related conditions as defined in California Welfare and

Institutions Code Section 4512(a)(1). Income and immigration status do not affect eligibility. Services are guided by the Individual Program Plan (IPP) and may include:

- In-home or out-of-home respite.
- Independent living and supported living services.
- Community care facilities.
- Day care supplements.
- Employment support.
- Safety-related supports, such as tracking devices or crisis services.

Division of Responsibilities

CenCal Health is responsible for providing primary care and all other medically necessary services, including comprehensive diagnostic evaluations and medically necessary BHT services. This includes responsibility for primary care, comprehensive diagnostic evaluations, and other medically necessary services. CenCal Health and its providers must ensure care coordination and share relevant member information with the Regional Center to support the identification and delivery of services outlined in the member's Individual Program Plan (IPP) or Individualized Family Service Plan (IFSP).

The Regional Center shall provide non-medical, Targeted Case Management (TCM) services to eligible members and their families to ensure timely access to health, developmental, social, educational, and vocational services. Targeted Case Management services must include coordination of services with CenCal Health to ensure non-duplication of services and appropriate referrals as identified in the members' IPP or IFSP.

Referral

Members may be referred by contacting the Regional Center to request an eligibility evaluation. The Regional Center evaluation process may take up to 90 days.

For more information regarding TCRC, please contact the specific county where a CenCal Health member currently resides or visit the Tri-Counties Regional Center website.

Santa Barbara County Offices:

Santa Barbara

- Phone: 805-962-7881 or 800-322-6994
- Fax: 805-884-7229

Santa Maria

- Phone: 805-922-4640 or 800-266-9071
- Fax: 805-922-4350

San Luis Obispo County Offices:

San Luis Obispo

- Phone: 805-543-2833 or 800-456-4153
- Fax: 805-543-8725

Atascadero
- Phone: 805-461-7402
- Fax: 805-461-9479

Reference Link:

Tri-Counties Regional Center
www.tri-counties.org/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

F5: Local Education Agency

A Local Education Agency (LEA) provides services to eligible members aged 3 years and older who are identified as Children with Special Health Care Needs (CSHCN) while in school.

A member may receive LEA services from their LEA in accordance with the member's Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP).

Division of Responsibility

CenCal Health is primarily responsible for providing all medically necessary services under the EPSDT benefit, including those that exceed what the LEA offers. Primary Care Providers must coordinate with LEAs to ensure delivery of medically necessary services outlined in a member's IEP or IFSP.

LEAs serve eligible members aged 3 and older with special health care needs while they are in school. Services are delivered according to the IEP or IFSP and are intended to support educational access and functional development.

The Children and Youth Behavioral Health Initiative (CYBHI) supports LEAs in providing behavioral health services at school or school-linked sites for youth under age 26 who are enrolled in public TK-12 schools or higher education institutions and are covered by Medi-Cal or other qualifying health plans.

Section G: Eligibility Verification and Enrollment for CenCal Health and CenCal CareConnect

This section applies to the following CenCal Health programs:

Medi-Cal

G1: Eligibility Frequently Asked Questions (FAQ)

CenCal Health currently serves approximately 227,000 residents in our service area of Santa Barbara and San Luis Obispo counties.

Does CenCal Health Determine Member Eligibility for its Medi-Cal Members?
No, the Department of Social Services (DSS) and/or each county's Social Security Administration determines Medi-Cal eligibility.

CenCal Health's Member Services Department provides help with:

- Understanding how the Health Plan works.
- Selecting a Primary Care Provider (PCP).
- Finding a specialist.
- Benefit education.
- Filing a grievance or appeal.
- Arranging interpreter services.
- Scheduling appointments.
- Replacing Health Plan identification cards.
- Transportation needs for those members who qualify.
- Translation and Alternative Format Services.
- Creating a personal Member Account on our member portal.

REMINDER: Always verify a member's eligibility status prior to treatment!
All providers are urged to verify member eligibility and PCP assignment (or Special Class status) prior to rendering services. This will serve to:

- Reinforce case management.
- Avoid possible referral/authorization/claims problems.
- Identify instances of member misrepresentation.

Who are Medi-Cal Special Class Members?
Any Medi-Cal contracted provider who is willing can see members who are Special Class. Special Class members are considered fee-for-service and are assigned to CenCal Health; therefore, they do not require Referral Authorization Forms (RAFs), though they may require a Prior Authorization Request when appropriate.

Categories for Special Class include:

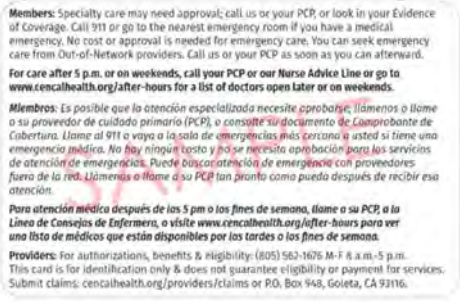
- The first month of eligibility.
- Members who reside in long-term care facilities (skilled nursing or institutions for the developmentally disabled).
- Members who have met their share-of-cost.
- Members in hospice.
- Members who reside out of county.
- Members who are qualified under the Genetically Handicapped Persons Program.

Are CenCal Health members issued ID cards?

Yes, CenCal Health members receive an identification card, as shown below. The group lists the program under which the members are covered.

Other information printed on the card includes member name, ID number, PCP name, and phone number. The back of the card will also have important numbers for emergency care, after-hours care, and the 24/7 Nurse Advice Line. These cards are issued only once and are reissued only when information on the card changes. These cards are intended only to be a means of identification. They are not considered proof of eligibility.





The state also issues a permanent plastic ID card for all Medi-Cal members, called the "Benefits Identification Card" or BIC. Currently, there are two versions of the BIC that members may present (see examples below).

The BIC is a permanent card and does not provide proof of eligibility. Providers must verify eligibility information using the information on this card through one of the various options made available.





How do I verify member eligibility?
Providers can access CenCal Health eligibility information using two options.

Option 1: Via CenCal Health website: www.cencalhealth.org

You can verify eligibility for CenCal Health members as well as state Medi-Cal members through our website. First, the provider must have an active web account. To create a web account, contact providerservices@cencalhealth.org. Once you are logged into the restricted "For Providers" section, click the Eligibility tab on the left-hand side and enter the CenCal Health Member ID and date of service. If the member is not eligible through CenCal Health, you have the option to check with DHCS for further eligibility information.

Option 2: Via CenCal Health's Member Services Department. Call the toll-free number: 1-877-814-1861, select Option 3.

A representative of the Member Services Department can provide information for CenCal Health-eligible members. Be prepared to give your provider's identification number (NPI).

Medi-Cal Eligibility Verification Options Available through the State
Note: Options for eligibility verification currently made available by the state do not take into account the need for providers to verify a member's PCP. PCP affiliation is important, as Referral Authorization Forms (RAFs) from the PCP are needed for most specialty services.

Automated Eligibility Verification Service (AEVS)
AEVS 1-800-456-2387 is a free telephone service provided by the state for Medi-Cal providers. AEVS requires the use of your Provider Identification Number (PIN).

What are Aid Codes?
An aid code is the two-digit alphanumeric number used to assist in identifying the types of services for which Medi-Cal recipients are eligible.

What if I see a Medi-Cal member who does not reside in the CenCal Health service area?
CenCal Health is a state-contracted Medi-Cal Managed Care plan that delivers care in San Luis Obispo and Santa Barbara counties. If a member resides in a different county, they may be eligible for another County Managed Care plan. Please check with the managed care plan in the county where the member resides for eligibility and guidelines. If the member is eligible for state Medi-Cal, you can bill Affiliated Computer Systems (ACS) following state Medi-Cal guidelines.

Is a CenCal Health member eligible to see a doctor out of county?
If a member is outside of the health plan's service area (Santa Barbara and San Luis Obispo counties) and needs medical services, they are instructed to call their PCP

unless it is an emergency or urgent situation. If it is an emergency or urgent situation, a member may go to the nearest urgent care facility, emergency room, or call 911. For non-urgent issues, a member's PCP must authorize any medical care with a referral (RAF). It is the provider's responsibility to check eligibility and obtain a RAF from the assigned PCP. Providers must be Medi-Cal* certified in order to be reimbursed.

**Out-of-state providers need to be Medicaid certified.*

This section applies to the following CenCal Health programs:

CenCal CareConnect (HMO D-SNP)

G2: Eligibility Frequently Asked Questions (FAQ)

How does a member become eligible with CenCal CareConnect?

A member must be eligible for Medicare parts A and B, have CenCal Health's Medi-Cal plan and reside within the service area to be eligible to enroll.

CenCal CareConnect Member Services provides help with:

- Understanding how the Health Plan works.
- Selecting a Primary Care Provider (PCP).
- Finding a specialist.
- Benefit education (including prescription and other supplemental benefits).
- Filing a grievance or appeal.
- Arranging interpreter services.
- Scheduling appointments.
- Replacing Health Plan identification cards.
- Transportation needs for those members who qualify.
- Translation and Alternative Format Services.
- Creating a personal Member Account on the member portal.

REMINDER: Always verify a member's eligibility status prior to treatment!

All providers are urged to verify member eligibility and PCP assignment prior to rendering services. This will serve to:

- Reinforce case management.
- Avoid possible referral/authorization/claims problems.
- Identify instances of member misrepresentation.

Are CenCal CareConnect members issued ID cards?

Yes, CenCal CareConnect members receive an Identification Card, as shown below.

Other information printed on the card includes the member's name, ID number, Care Management's phone number, PCP name and phone number, along with pharmacy processing information (including BIN, PCN, and Group numbers). The back of the card

also includes important numbers and contact information for emergency care, after-hours care, the 24/7 Pharmacy Help Desk , the 24/7 Nurse Advice Line, and the claims mailing address. These cards are intended only to be a means of identification. They are not considered proof of eligibility.



The state also issues a permanent plastic ID card for all Medi-Cal members, called the "Benefits Identification Card," or BIC. Currently, there are two versions of the BIC that members may present (see examples below).

The BIC is a permanent card and does not provide proof of eligibility. Providers must verify eligibility information using the information on this card through one of the various options made available.





How do I verify member eligibility?

Providers can access CenCal Health eligibility information using two options.

Option 1: Via CenCal Health website: www.cencalhealth.org

You can verify eligibility for CenCal Health members, as well as state Medi-Cal members, through our website. First, the provider must have an active web account. To create a web account, contact providerservices@cencalhealth.org. Once you are logged into the restricted "For Providers" section, click the Eligibility tab on the left-hand side and enter the CenCal Health Member ID and date of service.

Option 2: Via CenCal Health's Member Services Department. Call the toll-free number: 1-877-814-1861, select Option 1.

A representative of the Member Services Department can provide information for CenCal CareConnect-eligible members. Be prepared to give your provider's identification number (NPI).

Is a CenCal CareConnect member eligible to see a doctor out of county?
If a member is outside of the health plan's service area (Santa Barbara and San Luis Obispo counties) and needs medical services, they are instructed to call their PCP unless it is an emergency or urgent situation. If it is an emergency or urgent situation, a member may go to the nearest urgent care facility, emergency room, or call 911. For non-urgent issues, a member's PCP must authorize any medical care with a referral (RAF). It is the provider's responsibility to check eligibility and obtain a RAF from the assigned PCP.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

G3: Share of Cost (SOC) Frequently Asked Questions (FAQ)

What is Share of Cost?
Share of Cost (SOC) is a monthly dollar amount that a member is required to pay before they become eligible for Fee-for-Service (FFS) Medi-Cal or CenCal Health. The SOC amount is based on the income information supplied by the member to their eligibility worker at the Department of Social Services.

Please note for CenCal CareConnect eligibility: The only SOC members who are able to enroll into CenCal CareConnect are Long-Term Care (LTC) SOC members. All other members with a SOC will still be eligible under their primary Medicare coverage, along with CenCal Health coverage once their SOC is cleared each month.

CenCal Health is not involved with determining SOC or eligibility.
Note: If the member does not have any medical expenses for a particular month, no SOC is paid.

Is a Share of Cost (SOC) a Copay?
No, a Medi-Cal recipient's SOC is similar to a private insurance plan's out-of-pocket deductible. This SOC is monthly and is based on the amount of income a recipient receives in excess of "maintenance need" levels (determined by the state). Medi-Cal rules require that recipients pay income in excess of their "maintenance need" level toward their own medical bills before Medi-Cal begins to pay.

To whom does the member make an SOC payment?
A patient can pay or make a payment plan for their SOC with any Medi-Cal provider.

SOC can also be met with providers who are not Medi-Cal certified. In this case, the member must get a receipt with the following information: provider name, pre-printed company letterhead, procedure code, date of service, and total amount paid. The patient must take this to their eligibility worker to have the amount paid applied toward their SOC. Additionally, the patient can pay providers who are not medical providers (such as dentists) or pay for services that are not normally Medi-Cal benefits, such as non-formulary medications and circumcisions.

What does "payment plan" mean?
If a patient cannot pay the total SOC amount or has a large SOC and needs to make payments, the patient can make a payment plan with the provider. This is sometimes called obligating the SOC. The payment arrangements will be entirely between the patient and the provider. CenCal Health suggests that this agreement be in writing.

Important: When arrangements are made to accept payments for the SOC amount owed, the entire SOC amount owed should be cleared immediately. Providers should never wait to clear the SOC until the entire amount is paid. This may keep the patient from obtaining other medical services if needed.

SOC patients are considered "cash pay" patients until their SOC is met for a particular month. If the member does not fulfill an obligation, your office policy for "nonpayment" can apply. CenCal Health is not responsible and cannot be billed.

When does a SOC patient become Medi-Cal eligible?
When the patient meets their monthly SOC and the provider clears the SOC amount as described below.

What does "meeting share of cost" mean?
This means a patient's total SOC amount has been paid.

What does "spending down SOC" mean?
This means the provider has applied or cleared SOC with the state.

How do I apply or clear SOC?
Providers collect payments from the patient or accept the patient's payment plan to pay for services that are rendered up to this SOC amount. Providers should immediately submit a SOC clearance transaction to the state using either of the methods below.

State Medi-Cal Website Clearance:
DHCS Provider Portal (https://provider-portal.apps.prd.cammis.medi-cal.ca.gov/login)
Providers must have a Medi-Cal provider number, PIN number, and have a Medi-Cal Point of Service (POS) Network/Internet Agreement form on file.

For information on provider enrollment, visit the New Medi-Cal Provider enrollment page: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/page/new-provider

Please call the Telephone Service Center (TSC) at 1-800-541-5555 for more information. A provider's failure to clear the patient's SOC immediately may prevent the patient from receiving necessary services or medicine, despite having fulfilled the SOC obligation.

Remember: the state, not CenCal Health, clears the SOC. Although CenCal Health has the ability to transmit this information to the state, records are not kept in our database. We strongly suggest that you print out the information and place it in the member's file.

Why does a patient's SOC amount change?

Depending upon fluctuations in the patient's monthly income, SOC amounts may change from month to month. Additionally, if a patient's SOC is partially met by multiple providers, different "remaining" SOC amounts will appear during eligibility verification, until the total SOC is satisfied for that month. CenCal Health strongly suggests verifying eligibility at every visit to get updated SOC information.

Do SOC recipients have PCPs?

No, the recipient will not have a PCP. Once a patient meets the total SOC obligation, they will become eligible for either FFS Medi-Cal or CenCal Health. At that time, they are classified as "Special Class" members (not case managed). The member's PCP will appear as "CenCal Health" when verifying eligibility.

What is an LTC SOC?

This type of SOC is associated with a Long-Term Care (LTC) Facility. This SOC is paid to the nursing facility by the patient before the LTC can send a claim to Medi-Cal for the remaining difference. This SOC is always handled by the LTC on their monthly billing; other medical providers are not affected. If you are not an LTC provider, do not charge a SOC to the patient who resides in an LTC.

* LTC SOC members are able to enroll in CenCal CareConnect.

Do I need to submit a TAR for approval if the patient has a SOC?

If the total SOC amount will not cover the full billed charges and the CenCal Health Medi-Cal allowable payment for the provider would be higher than the SOC amount, providers should follow the usual procedures for TAR approval. This authorization, and a cleared SOC, will allow you to bill CenCal Health the difference.

Example: Member has a SOC of $50.00. The billed charges for the TAR-required procedure are $250.00. CenCal Health Medi-Cal allowable is $150.00. You will need to submit a TAR for authorization, spend down the SOC, and after the TAR is approved and the member is eligible with CenCal Health, bill for the remaining balance owed. CenCal Health pays up to the allowable, minus the SOC payment.

Do I submit a claim for a SOC patient?

If the patient's SOC equals or exceeds your total charges, do not submit a claim to CenCal Health. The paid/obligated SOC is considered the full payment, and CenCal Health will not pay more than that amount.

Additional payment may be considered only when the SOC payment you receive is less than the CenCal Health allowable amount and the patient's SOC has been met, making them eligible. If you submit a claim, you will need to enter the SOC information (see "Where do I put the SOC information?" below).

Where do I put the SOC information on the claim?

Medical & Allied Health Providers

On the CMS 1500, claim forms enter the "claim codes" in box 10D and the amount paid in Box 29.

For providers who bill on UB-04 Claim Forms

On the UB-04, claim forms enter the amount paid in Box 39-41 (value codes amount).

Section H: Referrals and Authorizations

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H1: Medically Necessary Services

Medically Necessary Services are those services determined to be reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. These services, supplies, equipment, and therapies are covered benefits of CenCal Health, including those services that exceed the services provided by Local Educational Agencies (LEA), Regional Centers (RC), or local governmental agencies and are determined to be:

- Appropriate and necessary to diagnose a condition or to treat the symptoms, diagnosis, illness, or injury.
- In accordance with evidence-based, professional, and nationally recognized clinical criteria, approved by CenCal Health and developed with practicing healthcare providers, which are updated when necessary and at least annually.
- Not primarily for the convenience of the member, or the member's physician or other provider.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services, in accordance with the parity in mental health and substance use disorder requirements in 42 CFR section 438.900, et seq.

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

CenCal CareConnect is responsible for reviewing all prior authorizations for the CenCal CareConnect services that are billed on a pharmacy claim, such as the review of Prior Authorizations for physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient drug claims billed on a pharmacy claim by an outpatient pharmacy

References:

Title 22 CCR, Section 51303(a), CenCal Health Contract 08-85212, Exhibit E, Attachment 1

CenCal Health Policy- Separation of Medical and Financial Decision Making (MM-UM24)

CenCal CareConnect Member Handbook

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H2: Sensitive Services

All CenCal Health members have the right to confidentiality when receiving sensitive services or family planning services. Sensitive services mean services that are related to pregnancy, family planning, sexually transmitted diseases, sexual assault, and substance or alcohol abuse. 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 18, they do not need the consent of their parent or guardian to receive these services. Members may obtain these services directly from their Primary Care Provider (PCP) or from 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

Primary Care Providers, county clinics, family planning providers, gynecologists, mental health providers, obstetricians, or multi-specialty groups can provide sensitive services. Please refer to your Contracted Provider Listing for a listing of providers.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H3: Request for Authorization

This section applies to Medi-Cal:
Providers may submit prior authorization requests via CenCal Health's Provider Portal. Alternatively, providers may choose to fax a completed prior authorization form (RAF, 50-1, 20-1, 18-1) to the Utilization Management Department at 805-681-3071.

Please refer to Section H to determine which form to use when submitting your request: RAF (Referrals), 50-1 (Outpatient), 20-1 (Long-Term Care), or 18-1 (Inpatient Admissions). In general, the services listed below require prior authorization from CenCal Health before rendering services:

- Psychological & neuropsychological testing
- Behavioral health treatment services (BHT)
- Scheduled (elective) surgery
- Non-emergent medical transportation (NEMT)
- Non-emergent inpatient admissions, including Acute Inpatient and Rehab, Skilled Nursing Facilities (SNF), Congregate Living Health Facility (CLHF), Subacute Care, Long-Term Acute Care (LTAC)
- Hearing aid(s)
- Durable Medical Equipment (DME)
- Orthotics
    - Therapeutic diabetic shoes and inserts
- Prosthetics
- Home health services (nursing, OT, speech, and PT)
- Outpatient therapy for members 21 years and older (PT after first 18 visits)
- Home infusion therapy
- Genetic testing
- Services with unlisted/miscellaneous procedure codes
- Wound care and medical supplies
- Services in or with non-contracted and out-of-network providers, including tertiary care facilities
- Radiology and Imaging Services, such as CT, CTA, MRI, MRA, PET, PET/CT, Nuclear Medicine
    - Submit your request to Premier Health via:

- Phone: 888-318-0276, Monday through Friday, 5 a.m. to 5 p.m.
- Fax: 888-717-9660
- https://cencalh.sharepoint.com/sites/CenCalHealthProviderManual/Shared Documents/2026 Provider Manual/2026 Provider Manual - Merged/Premier Health's PortalPremier Health's Portal at https://cencal.careportal.com/

To determine if a proposed treatment, therapy, procedure, or service code requires a prior authorization, please use our Procedure Code Look Up.

Reference Link:

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

Reference:

CenCal Health Policy & Procedure HS-MM49 Utilization Review – Prior Authorization, Concurrent Review, and Retrospective Review.

This section applies to CenCal CareConnect:

Individual authorization requests are reviewed by the Utilization Management Department (UM) in accordance with policy UM-HS 22 Clinical Criteria for Utilization Management Authorization Decision and medical information from the physician or other provider. In some cases, the UM Department may need to contact the provider directly to request additional information.

Prescribing/treating/ordering physicians may request authorization by completing the appropriate electronic Prior Authorization Request (PAR) form, attaching clinical documentation to support the request, and submitting through the Provider Link. Alternatively, a treating/requesting provider/physician may choose to fax a completed prior authorization form to the Utilization Management Department at 805-562-1082.

For CenCal CareConnect, a request for authorization may be made by:

a. Contract or non-contracted provider/physician who furnishes, or intends to furnish, services to the member.
b. If a member has a question about whether or not the plan will cover an item or service, the member, the member's representative, or the provider on behalf of the member, may request approval from the plan. This request is considered a request for service and will be processed in accordance with the applicable regulatory requirements.
    a. If a member requests a medical service or item either by phone or in writing, the UM Department will contact the provider for medical necessity information for the review of the request.

In general, the services listed below require prior authorization from CenCal CareConnect before rendering services:

- Durable Medical Equipment
- Experimental and Investigational procedures, and new technologies
- Genetic testing
- Hearing aids/services
- Home infusion therapy
- Home health services (nursing care, OT, ST, PT)
- Inpatient admissions, including Acute Inpatient and Rehab, Skilled Nursing Facilities (SNF), Intermediate Care Facilities, Subacute Care, Long-Term Acute Care (LTAC)
- Inpatient admissions for acute inpatient psychiatric treatment, partial hospital psychiatric treatment, and substance use disorder, including detoxification
- Medications
- Non-emergent medical transportation (NEMT)
- Nuclear medicine procedures/tests
- Orthotics
- Outpatient therapy (PT, ST, and OT after the first 18 visits)
- Prosthetics
- Psychological & neuropsychological testing
- Scheduled (elective) surgery
- Services with unlisted/miscellaneous procedure codes
- Services in or with non-contracted and out-of-network providers, including tertiary care facilities
- Wound care and medical supplies
- Radiology and Imaging Services, such as CT, CTA, MRI, MRA, PET, PET/CT
    - Submit your request to Premier Health via:
        - Phone: 888-318-0276, Monday through Friday, 5 a.m. to 5 p.m.
        - Fax: 888-717-9660
        - Premier Health's Portal at https://cencal.careportal.com/

References:

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Effective November 18, 2024

HS-CCO3 Utilization Review –Prior Authorization, Concurrent Review, and Retrospective Review (Medicare)

Reference Link:

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

This section applies to the following CenCal Health programs:

Medi-Cal

H4: RAF Exceptions

In general, a Referral Authorization Form (RAF) is required for all CenCal Health members seeking services outside of their primary care medical home; 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 related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care, and intimate partner violence.
- Limited services, including acupuncture, chiropractic, and audiology and hearing evaluations. Authorization for acupuncture and chiropractic visits are required if exceeding two visits per month of any of the limited services above (i.e., one chiropractic visit and one acupuncture visit).
- Physical therapy services include treatment prescribed by a physician or podiatrist of any bodily condition by the use of physical, chemical, and other properties of heat, light, water, electricity, or sound, and by massage and active, resistive, or passive exercise. Prior authorization is required for services beyond 18 visits.
- Emergency services.
- Mental health psychotherapy.
- Mental health medication management services.

Reference Link:

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

This section applies to the following CenCal Health programs:

Medi-Cal

H5: Medi-Reservations

"Medi-Reservation" (Medi-Res) is a Medi-Cal utilization management process used for certain limited services. It pertains to a method of limiting the Medi-Services (or "Limited Services") allowed under the Medi-Cal program, whereby a member is entitled to two visits or services per month.

Medi-Reservation – CenCal Health members
Services must be reserved by providers for each visit to be provided. Services may be reserved by completing and submitting the Medi-Reservation Form found on the CenCal Health website. A confirmation number will be given once the service is reserved.

Services Requiring a Medi-Reservation include:

- Audiology (audiology testing)
- Chiropractic services
- Acupuncture

For more information about Medi-Reservations, please visit the DHCS Medi-Cal Providers website: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/

Reference Link:

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H6: Medical Decision-Making Guidelines

CenCal Health ensures that its Utilization Management (UM) authorization decisions for its members' care are based on the medical necessity of a requested health care service, consistent with clinical criteria and/or guidelines supported by sound, evidence-based medical principles.

Decisions to deny or to authorize an amount, duration, or scope that is less than requested are made by a qualified health care professional with appropriate clinical expertise in the medical or behavioral health condition.

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

Approved CenCal Health guidelines are used for all medical necessity determinations, including but not limited to:

- Medicare Coverage Manuals
- Medicare Benefit Policy Manuals
- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)
- Medi-Cal Provider Manual
- MCG Guidelines
- CenCal Health Policies and Procedures

- Peer Review, evidence-based data, and literature review
- CCS Numbered Letters - DHCS

Reference:

CenCal Health Policy & Procedure MM-UM22 Clinical Criteria for Utilization Management Authorization Decisions

Reference Links:

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

DHCS Audiology and Hearing Aids (AUD)
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D935351C-3069-4C4B-A1CC-A0280ABE96B4/audio.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

DHCS Orthotics and Prosthetics (OAP)
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/54159021-7D67-4BB3-9FE0-33BB3D189F00/orthoauthpros.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

DHCS Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories (durable wheel)
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/3E27D197-BFAC-4236-865F-D938BC445BF0/durawheelguide.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

Medicare Claims Processing Manual
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H7: Urgent (Expedited) and Urgent Care

Urgent (Expedited) Authorization Request

An urgent authorization request is appropriate when a provider indicates or CenCal Health determines that following the routine timeline could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Urgent prior authorization requests will be processed within 72 hours of CenCal Health's receipt of the request unless additional information is required.

A retroactive authorization request is not considered urgent.

Urgent Care

Urgent care services are covered services for conditions that are not life-threatening but could result in serious injury or disability to the member unless medical attention is received. Urgent care applies to an episodic physical or mental condition perceived by a member as serious but not life-threatening that disrupts normal activities of daily living and requires assessment by a healthcare provider, and if necessary, treatment within 24-72 hours. Some examples include:

- Minor accidents and falls.
- Sprains and strains.
- Moderate back problems.
- Breathing difficulties (i.e., mild to moderate asthma).
- Bleeding/cuts requiring stitches.
- Eye irritation and redness.
- Fever or flu.
- Vomiting, diarrhea, or dehydration.
- Severe sore throat or cough.
- Minor broken bones and fractures (i.e., fingers, toes).
- Skin rashes and infections.
- Urinary tract infections.

References:

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

CenCal Health Policy and Procedure HS-MM-49 Utilization Review Prior Authorization, Concurrent Review, and Retrospective Review

CenCal Health Policy and Procedures HS-CC03 Utilization Review - Prior Authorization, Concurrent Review, and Retrospective Review

Reference Link:

CMS Integrated Appeals and Grievances
www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

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

This section applies to Medi-Cal:

CenCal Health's Transitional Care Services (TCS) Program assists members who are transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports

placements (including Sobering Centers, Recuperative Care, and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings to facilitate safe and successful transitions. Hospitals and facilities shall coordinate discharge planning in coordination with CenCal Health's TCS team. Admission, Discharge, and Transfer data must be submitted to CenCal Health for effective transitions of care.

CenCal Health has a dedicated team to support transitioning members when they request assistance. The team assists members with any transitions of care needs, including help with access to ambulatory care, appointment scheduling, medication reconciliation, transportation, and referrals to Enhanced Care Management (ECM), Community Supports (CS), needed social services or community-based resources. Providers can call the TCS Phone Line at 805-562-1044 or email TCSteam@cencalhealth.org.

This section applies to CenCal CareConnect:

The assigned CenCal CareConnect care manager assists members who are transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care, and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings to facilitate safe and successful transitions.

Hospitals and facilities shall coordinate discharge planning in coordination with the CenCal Health UM Department. The UM RN will be notified of the admission, discharge, and transfer data (ADT), which must be submitted to CenCal Health for effective transitions of care. The UM RN will work closely with the care manager/coordinator to address any changes in the member's condition and/or treatment/discharge plan. The UM nurse will notify the care management team of discharge notifications.

CenCal Health has a dedicated CenCal CareConnect care manager to support transitioning members when they have had a transition of care. The care manager assists members with any care coordination needs, including help with access to ambulatory care, appointment scheduling, medication reconciliation, transportation, and referrals to needed social services or community-based resources, including coordination of transportation services. The CenCal CareConnect care manager will update the individualized care plan to reflect on the recent admission and conduct an Interdisciplinary Care Team (ICT) meeting as applicable.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H9: Referrals for Specialist Services

This section applies to Medi-Cal:

Except for emergent, urgently needed services, or mental health services; or as otherwise noted in this Manual, applicable member's benefit package, or applicable state or federal laws; specialist shall not provide specialist services to members when there is no existing PCP referral to the specialist. The PCP needs to complete a Referral Authorization Form (RAF) via Provider Portal, fax, or secure link when specialist care is needed for a member.

Please see Section E12 Mental Health Services.

This section applies to CenCal CareConnect:

Members or their representative may make a request for all types of decisions about coverage under both Part C and Part D. Requests submitted by a member are requests for an organization determination and must comply with the applicable regulatory requirements.

Other parties that may request an initial determination include:

Type of Request	Who May Request
Part C, Standard Request for Item, Service, or Part B Drug	• Contract or non-contract provider/physician that furnishes, or intends to furnish, services to the enrollee. • Staff of said provider's/physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider).
Part C, Expedited Request	• A physician or staff of said physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead).
Part C, Payment Request	• Contract or non-contract providers.
Part D, Standard or Expedited Request	• An enrollee's prescribing physician or other prescriber.* • Staff of said prescriber's office acting on said prescriber's behalf (e.g., request is on said prescriber's letterhead or comes from the prescriber office fax machine).
Part D, Payment Request	• For direct member reimbursement, only an enrollee or an enrollee's representative (which may be the prescribing physician or other prescriber*) may request reimbursement under Part D.

References:

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

Reference Link:

CMS Integrated Appeals and Grievances

www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H10: Follow-Up Specialist Services

This section applies to Medi-Cal:

Specialists shall coordinate the provision of specialist services with the member's PCP in a prompt and efficient manner, except in the case of an emergency medical condition. The specialist shall not provide any follow-up or additional specialty services to members other than the services indicated within the duration and frequency indicated on the Referral Form (RAF) provided to the specialist by CenCal Health or the PCP.

Within 10 business days of providing specialist services to a member, the specialist shall provide the member's PCP with a written report regarding the member's medical condition in such form and detail reasonably acceptable to the member's PCP and CenCal Health. The specialist shall always promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation, obtaining the appropriate pre-authorization should a member require additional or follow-up covered services beyond those indicated on the RAF.

Except in the case of emergency or urgently needed services, specialists shall refer members back to the member's PCP when the specialist determines the member requires the services of another specialist physician.

This section applies to CenCal CareConnect:

Contracted or non-contracted provider/physicians who furnish or intend to furnish services to the member may request an initial determination or request care. Follow-up care requests for ongoing specialist visits are reviewed for medical necessity in accordance with Medicare Guidelines and Criteria and in accordance with Part C & D Enrollee Grievances, Organization Determinations, and Appeals Guidance, Section 40.

Within 10 business days of providing specialist services to a member, specialists shall provide the member's PCP with a written report regarding the member's medical condition in such form and detail reasonably acceptable to the member's PCP and CenCal Health. Specialists shall always promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation, obtaining the appropriate pre-authorization should a member require additional or follow-up covered services.

References:

Part C & D Enrollee Grievances, Organization Determinations, and Appeals Guidance, Section 40

CenCal Health Policy & Procedure HS-MM 49: Utilization Review - Prior Authorization, Concurrent Review, and Retrospective Review

CenCal Health Policy & Procedure HS-CC03: Utilization Review - Prior Authorization, Concurrent Review, and Retrospective Review

Reference Link:

CMS Integrated Appeals and Grievanceswww.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H11: Out-of-Network Services

Any non-emergent or non-urgent services rendered by non-participating, non-contracted providers or facilities must be pre-authorized by CenCal Health and must meet the member's medical need for specialized or unique services that CenCal Health considers unavailable within the existing network.

When required, requests for out-of-network services are reviewed by CenCal Health on a case-by-case basis. Determinations are made based on the member's medical needs and the availability of services within CenCal Health's practitioner and provider network to meet these needs and coverage limits. CenCal Health provides its clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management, and retrospective review to all providers, including out-of-network providers, providing services to its members.

All providers, including out-of-network providers, can request CenCal Health's clinical protocols and evidence-based guidelines by calling the Utilization Management Department at 805-562-1082. For Medi-Cal, callers select Option 1; for CenCal CareConnect, callers select Option 2.

CenCal Health ensures that all out-of-network providers that provide services to its members adhere to clinical protocols and evidence-based practice guidelines governing Prior Authorization (PA), Utilization Management (UM), and retrospective review.

The requesting provider or facility needs to complete and submit a Prior Authorization Request (TAR)/Prior Authorization Request form to CenCal Health for review. If CenCal Health approves the member to go out of network, the cost to the member is not greater than it would be if the services were provided in-network.

CenCal Health adheres to all required timeframes in accordance with CenCal Health policies and procedures regarding timelines and notifications.

References:

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

CenCal Health Policy and Procedure HS-MM49: Utilization Review Prior Authorization, Concurrent Review, and Retrospective Review

CenCal Health Policy and Procedure HS-CC03: Utilization Review - Prior Authorization, Concurrent Review, and Retrospective Review

Reference Link:

CMS Integrated Appeals and Grievances
www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H12: Second Opinions

Members have access to a second medical opinion regarding a recommended procedure or service through their PCP. CenCal Health and CenCal CareConnect will authorize a second opinion based on, but not limited to, the following criteria:

a) In any instance in which the member questions the reasonableness or necessity of the recommended procedure/surgical procedure.
b) A member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
c) Clinical indicators are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition, and the member requests a second opinion regarding an additional diagnosis.
d) The treatment plan in progress is not improving the member's condition within an appropriate period of time, given the diagnosis and plan of care, and the

member requests a second opinion regarding the diagnosis or continuance of the treatment.

e) A member has attempted to follow the plan of care or consulted with the initial provider regarding serious concerns about the diagnosis or plan of care.

CenCal Health and CenCal CareConnect will authorize a request for a third opinion if the recommendations of the first and second practitioners differ regarding the need for a medical or surgical procedure, and a request is received from the member, authorized representative, or physician requesting such a third opinion.

CenCal CareConnect will allow a second opinion from a qualified health professional within the network, if available.

If the member selects a contracting provider/specialist, the PCP may enter a RAF/Prior Authorization Request via Provider Portal or fax a completed RAF/Prior Authorization Request to CenCal Health to process the second opinion.

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H13: New Medical Technologies

To provide the best possible services, CenCal Health and CenCal CareConnect through the established Benefit Committee makes determinations and recommendations on whether current non-benefits, including experimental/investigational procedures devices, or services, as well as new applications of current benefits, should be added or removed from CenCal Health's benefit package in alignment with regulatory requirements or recommendations. The Benefit Committee process includes, but is not limited to, evaluating the effectiveness of benefits to members and the costs of possible changes to CenCal Health benefits. The Benefit Committee will address the suggested changes from its contracted provider network, its members, plan staff, and outside community-based partners as appropriate.

CenCal Health's Benefit Committee may determine when additional expertise is required and confirm with the Medical Director the appropriate external specialists for the specialist review. Once a specialist type is identified, a request will be sent to the appropriate specialist for review utilizing CenCal Health and CenCal CareConnect's contracted Board-Certified Specialist Vendor via the electronic referral request.

The Benefits Committee will address suggested changes from its contracted provider network, its members, Plan staff, and outside Community Based Partners as appropriate in addition to new technology and new applications for existing technology introduced as a result of legislation or FDA approval. CenCal Health and CenCal CareConnect's behavioral healthcare professionals are involved in the decision-making process for behavioral healthcare services when behavioral health technology is reviewed.

The Benefit Committee reviews include evaluation of appropriate information from government regulatory bodies, including the FDA, CMS, and Agency for Healthcare Research and Quality (AHRQ), and reviews relevant scientific information that may include, but is not limited to:

Articles published in peer-reviewed scientific literature. The scientific evidence must identify conclusions concerning the effect of technology on health outcomes.

a. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered when evaluating the evidence.
b. The evidence should demonstrate that the technology can measure or alter physiological changes related to a disease, injury, illness, or condition. In addition, there should also be evidence or a convincing argument based on established medical facts that such measurements or alterations affect health outcomes.

CenCal Health and CenCal CareConnect may research, review, and adopt evidence-based clinical guidelines developed by nationally recognized health care organizations or the plan's clinical guidelines and/or use licensed clinical professionals in the evaluation of each recent technology.

Technology must improve net health outcomes. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

Additionally, and in the absence of established and relevant UM criteria, CenCal Health, in consultation with practitioners of appropriate specialties and technological expertise, may develop clinical criteria to use in the decision-making of newly adopted technologies based on medical necessity.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H14: Continuity of Care

This section applies to Medi-Cal:

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

- New members who mandatorily transitioned from Medi-Cal Fee-For-Service to enroll as CenCal Health members.
- New members who are transitioning from Medi-Cal managed care plans (MCPs) with contracts expiring or terminating to a new MCP due to a contract termination or expiration with DHCS. New members who wish to continue care with a terminated provider.
- New members, in accordance with state law, and/or CenCal Health's contractual terms and requirements within the Department of Health Care Services.
- New members in accordance with the appropriate application of continuity of care in accordance with the Department of Health Care Services Managed Care Program Data Improvement Project.
- Current members whose mental health condition has stabilized, such that the member no longer qualifies to receive Specialty Mental Health Services from the mental health plan, and they become eligible to receive Non-Specialty Mental Health Services from CenCal Health.

Providers may request continuity of care on behalf of the member, or the member may make that request themselves by contacting Member Services.

CenCal Health members may request continuity of care with any out-of-network provider with whom the member has had a preexisting relationship for up to 12 months. The member must have seen the provider within the past 12 months; CenCal Health must be able to determine a preexisting relationship (self-attestation is not enough).

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

This section applies to CenCal CareConnect:

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

- New members who became CenCal CareConnect members enrolled as CenCal Health members on January 1, 2026.
- New members, in accordance with state law, and/or CenCal Health's contractual terms and requirements within the Department of Health Care Services.
- New members in accordance with the appropriate application of continuity of care in accordance with the Department of Health Care Services Managed Care Program Data Improvement Project.

Providers may request continuity of care on behalf of the member, or the member's representative may make that request themselves by contacting Member Services.

CenCal Health members may request continuity of care with any out-of-network provider with whom the member has had a preexisting relationship for up to 12 months.

The member must have seen the provider within the past 12 months; CenCal Health **must be able to determine** a preexisting relationship (self-attestation is not enough).

CenCal Health has 30 days to respond to your request. However, if the services are requested or needed urgently and the request has been expedited, CenCal Health will respond in 15 days.

A request for Continuity of Care can also be made for Durable Medical Equipment for at least 90 days until a new DME rental and a network provider can deliver the equipment.

Continuity of Care does not apply to providers of transportation or other ancillary services.

After the continuity of care period ends, the member will need to use doctors and other providers in the CenCal CareConnect's network.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

H15: Authorization Guides

Attachment A: Medi-Cal Authorization Guide

Form	Type of Request or Service	Who Can Submit the Request	Purpose	Processing Timelines for URGENT Request	Processing Timelines for Routine Request
Referral Authorization Form (RAF)	Referral from PCP to Specialist, for a Second Opinion, or Standing Referral for extended care	PCP (and occasionally, designated Provider Services 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 7 calendar days from date of receipt of referral request
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 7 calendar days from date of receipt of referral request.
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 7 calendar days from date of receipt of referral.
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."

Attachment B: CenCal CareConnect Integrated Organization Determination

Type of Service Request	Decision	Favorable Determination	Partially Favorable or Adverse	Letter Template
Standard Request				
Standard Initial Organization Determination (Pre-service) Services have not yet occurred	As soon as medically indicated, within a maximum of 7 calendar days after receipt of request	Within 7 calendar days of receipt of request	Within 7 calendar days of receipt of request	Favorable: Organization Coverage Determination Notice Partially Favorable/Adverse: Coverage Decision Template
Standard Initial Organization Determination (Concurrent) Concurrent for services ongoing	As soon as medically indicated, within a maximum of 7 calendar days after receipt of request	Within 7 calendar days of receipt of request	Within 7 calendar days of receipt of request	Favorable: Organization Coverage Defemination Notice Partially Favorable/Adverse: Coverage Decision Template
Standard Initial Organization Determination **(PART B**	Within 72 hours of receipt of request	Within 72 hours of receipt of request	Within 72 hours of	Favorable: Organization Coverage

Drug) Services have not yet occurred			receipt of request	Determination Notice <u>Partially Favorable/Adverse:</u> Coverage Decision Template
Expedited Requests ***NOTE: Does not apply to retrospective reviews**				
Standard Initial Organization Determination (Pre-service) Services have not yet occurred	Within 72 hours after receiving the request for items and services	Provide verbal or written notification* of favorable decision to the enrollee (and the physician involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than: o 72 hours after receiving the request for items • If the MA plan initially provides verbal notification of its decision, it may deliver written confirmation of its decision within 3 calendar days of the verbal notification.	Provide written notification* to the enrollee of the decision (and the physician involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than: o 72 hours after receiving the request for items and services. • If the MA plan initially provides verbal notification of its decision, it must deliver written confirmation of its decision within 3 calendar days of the verbal notification.	<u>Favorable:</u> Organization Coverage Determinations Notice <u>Partially Favorable/Adverse:</u> Coverage Decision Template
Standard Initial Organization Determination	Within 72 hours after receiving the request for items and services	Provide verbal or written notification* of	Provide written notification*	<u>Favorable:</u> Organization Coverage

(Concurrent) Concurrent for services ongoing		favorable decision to the enrollee (and the physician involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than: o 72 hours after receiving the request for items • If the MA plan initially provides verbal notification of its decision, it may deliver written confirmation of its decision within 3 calendar days of the verbal notification.	to the enrollee of the decision (and the physician involved, as appropriate) as expeditiousl y as the enrollee's health condition requires, but no later than: o 72 hours after receiving the request for items and services. • If the MA plan initially provides verbal notification of its decision, it must deliver written confirmation of its decision within 3 calendar days of the verbal notification.	Determination Notice <u>Partially Favorable/Adverse:</u> Coverage Decision Template
Expedited Initial Organization Determination **(PART B Drug)** Services have not yet occurred	24 hours after receiving the request	Provide verbal or written notification* of favorable decision to the enrollee (and the physician involved, as appropriate) as expeditiously as the enrollee's health condition requires, but no later than: o 24 hours after receiving the request for items	Provide written notification* to the enrollee of the decision (and the physician involved, as appropriate) as expeditiousl y as the enrollee's health condition requires, but no later than:	<u>Favorable:</u> Organization Coverage Determination Notice <u>Partially Favorable/Adverse:</u> Coverage Decision Template

		• If the MA plan initially provides verbal notification of its decision, it may deliver written confirmation of its decision within 3 calendar days of the verbal notification.	o 24 hours after receiving the request for Part B drugs. • If the MA plan initially provides verbal notification of its decision, it must deliver written confirmation of its decision within 3 calendar days of the verbal notification.	
Expedited - If Expedited Criteria NOT met 1. If a request is made by an enrollee, the plan must expedite the request if it determines that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. 2. If a request is made or supported by a physician, prescribing physician, or other prescriber who indicates applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function (the physician does not have to use these exact words), the plan must process it as expedited. 3. If a request involves both a payment request and a request for approval of an item, service, or drug, the enrollee has a right to ask for an expedited initial determination for the approval request.				
If an Expedited Request does not meet criteria following MD Review	As soon as the determination is made but within the applicable timelines of the request type	NA	1. Transfer the Request to the standard initial determination process 2. Give the member prompt verbal notice of the denial to expedite the request 3. Deliver a	Fast Complaint Template- Does Not Meet Expedited Criteria

			written notice within 3 calendar days of the verbal notice to expedite the request	
Retrospective Request				
Retrospective Request Service has been completed	Within 30 calendar days	Within 30 calendar days	Within 30 calendar days	Favorable: Organization Coverage Determination Notice Partially Favorable/Adverse: Coverage Decision Template

Attachment C: CenCal CareConnect Hospital Discharge Appeal Notice and Termination of Provider Services

Type of Service Request	Decision	Important Message from Medicare	Detailed Notice of Discharge (DND)	Notice Content
Hospital Discharge Appeal Notice	Attending physician must concur with discharge from IP hospital to any other level of care. Continue coverage of inpatient care until physician concurrence obtained	Hospitals response to issue the IM within 2 calendar days of admission and obtain signature from member or representative	Upon notification from the QIO that the member or the representative has requested an appeal, the health plan or the hospital must issue the DND to both the member and the QIO as soon as possible but NO later than the day after the notification by the QIO Must include:	The DND must include: § A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. § A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization. § Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. § Facts specific to the member and

				relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case. § Any other information required by CMS
Type of Request	**Decision**	**Notice of Medicare Non-Coverage (NOMNC)**	**Detailed Explanation of Non-Coverage (DENC)**	**Detailed Explanation of Non-Coverage**
Termination of Provider Service **Skilled Nursing Facility **Home Health Agency **Comprehensive Outpatient **Rehabilitation Facility (CORF) **Hospice NOTE: This process does not apply to SNF Exhaustion of Benefits (100-day limit)	The Health Plan or delegate is responsible for making the decision to end services -no later than two (2) calendar days or 2 visits before coverage ends: § Discharge from SNF, HHA or CORF services -OR § A determination that such services are no longer medically necessary	CenCal Care Connect, SNF, HHA, or CORF is responsible for the delivery of the NOMNC to the member or the authorized representative. the NOMNC must be delivered even if the member agrees with the termination. - The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends and the QIO information The NOMNC may be delivered earlier if the date that coverage will end is known OR A determination that such services are no longer medically necessary	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal the Health CenCal CareConnect must issue the DENC to the QIO and member no later than close of business the day the QIO notifies CenCal CareConnect of the appeal	The DENC must contain: **The facts specific to the member's Discharge and provider's determination that coverage should end **A specific and detailed explanation of why services are either no longer reasonable and necessary **A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review. The notice must be provided in Spanish, if necessary

		The NOMNC must remain 2 pages, can be on both sides or 2 separate but can't be condensed to one page		

References:

Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

Section 40.10 Processing Timelines, Section 100 Provider Notices in Hospital, SNF, HHA, and CORF Sections (Part C Only)

Reference Link:

CMS Integrated Appeals and Grievances
www.cms.gov/files/document/dsnppartscdgrievancesdeterminationsappealsguidanceaddendum.pdf

This section applies to the following CenCal Health programs:

CenCal CareConnect (HMO D-SNP)

H16: Notification of Inpatient Facility Discharge Appeal Rights

Discharge Appeal Rights

Hospitals must notify CenCal CareConnect members about their inpatient Hospital Discharge Rights. Hospitals should use the standardized CMS Form, Important Message (IM) from Medicare, and shall include the following information:

a. The member's rights as a hospital inpatient, including the right to benefits for inpatient services and for post hospital services;
b. The member's right to request an immediate review, the process for immediate review, and other appeal options;
c. The circumstances under which the member will or will not be responsible for charges for continued stay in the hospital; and
d. The member's right to receive additional information

The Important Message is to provide such notice at or near admission to the hospital, but no later than two days after admission.

The member or their representative is to sign and date the notice as a means of valid notification. If the member refuses to sign the notice, the hospital shall document the date of refusal, which serves as the date the member received the notice.

Physician Concurrence

Prior to discharging a member from an inpatient hospital level of care, CenCal CareConnect must obtain concurrence from the physician who is responsible for the member's inpatient care.

Quality Improvement Organization (QIO)

A member has the right to request an immediate review by the QIO when CenCal CareConnect, with physician concurrence, determines that the inpatient care for the member is no longer necessary.

A member who wishes to file an immediate review must follow the steps listed on the IM. If the member does not make a time request to the QIO, the member may contact CenCal CareConnect to request an expedited reconsideration as outlined in the IM.

CenCal CareConnect

Upon notification, CenCal CareConnect must complete and deliver a Detailed Notice of Discharge (DND)to the member as soon as possible but no later than noon of the day after the QIO's notification, including any supporting medical records, including the IM and DND (if applicable).

CenCal CareConnect will deliver to the member a copy of any documentation that it sends to the QIO, including written records of any information provided by telephone. This document is to be delivered to the member no later than the close of business of the first day after the material is requested.

CenCal CareConnect remains financially responsible for continued coverage of the services during the QIO review process, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers.

The hospital may not charge CenCal CareConnect or the member if it was the hospital (acting on behalf of the member) that filed the request for immediate QIO review, and the QIO upholds the non-coverage determination made by CenCal CareConnect.

QIO Determination

If the QIO determines that the member still requires inpatient hospital care, the hospital must provide the member with a notice of discharge rights when the hospital or CenCal CareConnect once again determines that the member no longer requires inpatient hospital care.

If the hospital determines that inpatient hospital services are no longer necessary, the hospital may not charge the member for inpatient services received before noon of the day after the QIO notifies the member of its review determination.

NOTE: This process is **NOT** applicable to an Observation Stay.

This section applies to the following CenCal Health programs:

CenCal CareConnect (HMO D-SNP)

H17: Notice of Medicare Non-Coverage and Notice of Detailed Explanation of Non-Coverage

Notice of Medicare Non-Coverage

CenCal CareConnect is responsible for determining the discharge date for members receiving Covered Services from a Skilled Nursing Facility (SNF), Home Health Agency (HHA), Comprehensive Outpatient Rehabilitation Facility, or hospices.

CenCal CareConnect is required to provide a Notice of Medicare Non-Coverage (NOMNC) to members when their Medicare-covered service(s) are ending.

The NOMNC informs members how to request an expedited determination from their Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) and gives members the opportunity to request an expedited determination from a BFCC-QIO.

A Detailed Explanation of Non-Coverage (DENC) is given only if a beneficiary requests an expedited determination. The DENC explains the specific reasons for the end of covered services.

The NOMNC should not be issued if coverage is ending for any of the following reasons:

a) Because the Medicare benefit is exhausted
b) For denial of Medicare admission
c) For denial of non-Medicare covered services: or
d) Due to a reduction or termination of a Medicare service that does not end the skilled Medicare service.

Decision made to terminate services

When a decision has been made to terminate Covered Services for a member in a SNF, HHA, CORF, or hospice, the provider is required to prepare and deliver a NOMNC, using Form CMS-10123, to the member no later than two calendar days before the planned end of Medicare-covered services, in accordance with 42 C.F.R. § 422.624.
CenCal CareConnect shall notify the provider of the service termination date with sufficient time for the provider to deliver the NOMNC to the member within the timeline required by law.

If home health services are being provided less frequently than daily, the notice must be delivered no later than the next-to-last visit before Medicare-covered services end. The original notice is given to the member, and a copy should be retained in the member's medical record.

Providers are not required to agree with the termination decision, but Medicare rules still require them to issue the notice as instructed.

Providers should promptly inform CenCal CareConnect once the NOMNC has been delivered so that CenCal CareConnect can anticipate and prepare for a potential appeal.

No Covered Services shall be discontinued on the termination date unless a valid NOMNC has been delivered timely, or unless the member has expressly waived their right to notice.

CenCal CareConnect covers services until the date and time designated on the NOMNC, unless the member appeals and the Quality Improvement Organization (QIO) reverses the decision to terminate services.

Member Appeals and Expedited Review Process
The NOMNC informs the member of their right to an expedited appeal by the QIO.

The member should request an immediate review, by telephone or in writing, by noon on the first day after the day of delivery of the NOMNC. If the QIO is closed due to an emergency and is unable to accept the member's request for a fast-track appeal, the member must file a request by noon the next day that the QIO is open for business.

QIO Notification of the Appeal
When the QIO notifies CenCal CareConnect that a member has requested an appeal, CenCal CareConnect will execute and deliver (by direction or by delegation) a Detailed Explanation of Non-Coverage (DENC), to the member as soon as possible but no later than the close of business of the day of the QIO's notification to CenCal CareConnect. CenCal CareConnect will ensure delivery of the DENC, regardless of whether it has delegated that responsibility to its providers.

Upon notification, CenCal CareConnect must deliver to the member a copy of any documentation that it sends to the QIO, including written records of any information provided by telephone.

This documentation must be delivered to the enrollee no later than the close of business on the first day after the documentation is requested.

CenCal CareConnect will provide, directly or by delegation, all the information that the QIO needs to make its determination, including copies of the notices sent to the enrollee. This information must be delivered as soon as possible, but no later than the close of business of the day the BFCC-QIO notifies the MA plan of the enrollee's request.

CenCal CareConnect remains financially responsible for continued coverage of services during the QIO review, regardless of whether it has delegated responsibility for authorization coverage of discharge determinations to its providers.

QIO Determination
If the QIO delays its decision due to CenCal CareConnect's failure to provide necessary information or records in a timely manner, CenCal CareConnect shall accept liability for the costs of any additional coverage required by the delayed decision.

If the QIO defers the decision until receipt of the requested information from CenCal CareConnect, the member's coverage shall continue until the QIO makes a decision.

The QIO will make an official determination of the Medical Necessity of continued services and notify the member and CenCal CareConnect within 48 hours after receipt of a request for review.

- If the QIO upholds the initial Organization Determination, the member or member's authorized representative has the right to appeal the decision to the Administrative Law Judge (ALJ), the Medicare Appeals Council (MAC), or a federal court.
- If the QIO overturns CenCal CareConnect's termination decision, CenCal CareConnect shall authorize, or provide, the service as expeditiously as a member's health requires, but no later than 72 hours after receipt of the notice of the QIO's decision.
- If the QIO reverses the termination of services, CenCal CareConnect must re-evaluate the coverage rules and the member's continued status related to medical necessity and then must provide the member with a new Notice of Medical Necessity when termination of services is determined.

Section I: Care Management Programs and Community Support Services

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

I1: Utilization Management

CenCal Health maintains a Utilization Management (UM) Program to ensure appropriate processes are used to review and approve the provision of medically necessary covered services for members. The Chief Medical Officer, Medical Directors, and qualified licensed healthcare professionals are responsible for the utilization review process.

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

- Authorization decisions are based upon medical necessity of requested healthcare services and are consistent with criteria or guidelines supported by clinical principles that are evidence-based.
- UM does not pay, nor offer financial incentives or rewards to providers, employees, or other individuals for utilization management decisions.
- UM's policies and procedures related to authorization reviews are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
- CenCal Health makes all relevant Utilization Management policies and procedures available upon request.
- UM activities are integrated into the Quality Improvement Systems to review requests, denials, deferrals, modifications, appeals, and grievances to the medical director.
- CenCal Health maintains timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Limitations (NQTL) more stringently in mental health or substance use disorder services than are imposed on medical/surgical services.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

I2: Enhanced Care Management

This section applies to Medi-Cal:
CenCal Health offers Enhanced Care Management (ECM), a statewide Medi-Cal benefit available to selected "Populations of Focus" as part of California Advancing Innovating Medi-Cal (CalAIM) multi-year initiatives. ECM is designed to address the clinical and non-clinical needs of the highest-need members through intensive whole-person care coordination.

The Populations of Focus are:

- Individuals & Families Experiencing Homelessness (POF 1)
- Individuals At Risk for Avoidable Hospital and Emergency Department (ED) Utilization (POF 2)
- Individuals with Serious Mental Health/SUD Needs (POF 3)
- Individuals Transitioning from Incarceration (POF 4)
- Adults Living in the Community at Risk for Long-Term Care (LTC) Institutionalization (POF 5)
- Adult Nursing Facility Residents Transitioning to the Community (POF 6)
- Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition (POF 7)
- Children and Youth Involved in Child Welfare (POF 8)
- Birth Equity (Adults and Youth) (POF 9)

Members who are eligible for ECM are assigned to an ECM provider with expertise in serving the various Populations of Focus, and who will provide outreach to engage members to enroll in the program. Members who agree to participate in ECM will be assigned a Lead Care Manager who will meet the member wherever they are (e.g., street, shelter, skilled nursing facility) and who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for members to get the right care at the right time.

The ECM provider will offer the following seven ECM core components:

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

Primary Care Providers (PCPs) are an integral part of the member's care coordination team. PCPs can use the Provider Portal to determine whether a member is enrolled in

ECM, identify the member's assigned ECM provider, and access the ECM provider's contact information.

Referring Members to Enhanced Care Management

Providers are welcome to refer members who may benefit from ECM. ECM referrals may also be submitted by, but are not limited to, members or their authorized representatives and community or government agencies. To submit a referral request for ECM or to learn more about the Population of Focus criteria, visit www.cencalhealth.org/providers/enhanced-care-management/ http://www.cencalhealth.org/providers/calaim/or call our Member Services Department at 1-877-814-1861. We ask that you please allow five business days to determine eligibility and assign an ECM provider for member outreach. To find out if a member is currently receiving ECM services and to obtain the name and contact information for their ECM provider, please refer to the Case Management section in the Provider Portal.

ECM providers will refer to the CenCal Health Enhanced Care Management (ECM) Provider Reference Guide to obtain detailed policy information and other requirements regarding ECM eligibility, authorizations, billing, payment, utilization requirements, and program guidelines on the CenCal Health website at: www.cencalhealth.org/providers/enhanced-care-management/. Providers are expected to adhere to the additional guidance and requirements found in the ECM Provider Reference Guide.

This section applies to CenCal CareConnect:

Dual members who are eligible can receive ECM-like services through CenCal CareConnect under the California Integrated Care Management (CICM) program. CICM refers to California-specific requirements for integrated care coordination, ensuring vulnerable dual members have access to comprehensive, coordinated care tailored to their needs.

Members transitioning from ECM to California Integrated Care Management (CICM) may request up to 12 months of continuity of care with the current ECM provider. Members can refer to the Member Handbook for continuity of care requests.

For additional information and eligible populations for California Integrated Care Management (CICM), please refer to the Care Management Section.

Reference Links:

To learn more about ECM, visit:
https://www.cencalhealth.org/about-calaim/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

I3: Care Management (Complex and Care Coordination)

This section applies to Medi-Cal:

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

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

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

Each of the care management services promotes quality care and cost-effective outcomes that enhance the physical, psychosocial, and vocational health of individuals. It includes ongoing assessment of needs, planning, implementing, coordinating, and evaluating health-related service options. Members may self-refer to the Care Management programs. Referrals can also come from a variety of sources, such as the PCP, specialist physician, discharge planners, practitioners, Utilization Management team members, Medical Director, member/family, internal departments, and community-based organizations. Providers may request assistance in the development of care plans for the treatment of members with complex or serious medical conditions.

To learn more about ECM, please see the Enhanced Care Management Section.

CenCal Health Care Management

CenCal Health's Care Management (CM) services ensure members receive the right level of care across the continuum through person-centered interventions tailored to each member's health and social needs. Care is coordinated collaboratively with the members, their PCP, specialists, and the broader interdisciplinary team. This coordination extends across settings of care, other Medi-Cal managed care plans, delivery systems, programs (e.g., Targeted Case Management, Specialty Mental Health Services), external partners, and community resources, including services not covered by CenCal Health, to address member needs and social determinants of health.
CM services are provided by a team of registered nurses, social workers, and clinical support associates, primarily by phone, and are available to all adult and pediatric members. Members who agree to participate in Care Management services are assigned a Lead Care Manager, who will conduct a comprehensive assessment and develop an individualized care plan in collaboration with the member, the member's family, physician(s), and other healthcare professional(s). Members will receive education, support for self-management skills, and care coordination to access appropriate services and resources. Members may disenroll from care management

services at any time by contacting their Care Manager or the Care Management Department at 805-562-1082, Option 2.

Referrals to Care Management

Referrals may come from providers, discharge planners, practitioners' community partners, or through member self-referral (or by authorized representatives/caregivers). Members may qualify if they:

- Have complex or chronic medical conditions (e.g., CHF, diabetes, cancer, COPD, ESRD, transplants).
- Experienced traumatic or catastrophic injuries or illnesses.
- Are non-adherent to medical regimens (missed appointments, misuse of meds, poor diet).
- Are frequent ED users (e.g., two visits in three months) or have multiple hospital admissions/readmissions (within 30 days).
- Over- or under-utilize available medical services.
- Need coordination for services outside the network or pre-/post-surgical support.
- Have self-care deficits requiring education or one-on-one support.
- Face high psychosocial risks impacting health outcomes.
- Require help accessing community resources (Foodbank, Meals on Wheels, Family Resource Centers, Unity Shop).
- Have fragile conditions, cognitive changes, or need assistance with care transitions.
- Require coordination with specialized programs (LEA, Regional Centers, Drug Medi-Cal, County Mental Health).
- Need support transitioning between care settings (e.g., hospital to SNF, SNF to home, or non-contracted to contracted SNF).

How to Refer a Member to Care Management

Providers can be referred to care management by completing the Care Management Referral Form at www.cencalhealth.org and faxing it to 805-681-8260, or by calling the Health Services Central Line at 805-562-1082, Option 2, for assistance.

After a referral is received, the Care Management team will confirm receipt of the referral, determine if the member qualifies, and notify the provider. The Care Manager will reach out to the members within five business days of referral receipt or 72 hours for urgent cases and provide information about our services. If the member or their representative agrees to participate, a Care Manager will begin assessing the member's needs.

We're committed to working alongside you to ensure the best health outcomes for our members. Please contact the Care Management Department at 805-562-1082, Option 2, for any additional questions or support.

This section applies to CenCal CareConnect:

D-SNP Care Management and Coordination

CenCal CareConnect provides a comprehensive care management program designed to address the complex medical, behavioral, and social needs of dual-eligible members. Each member is assigned to a dedicated nurse care manager and care coordinator who serve as the primary points of contact to support the member throughout their care journey. The care team collaborates closely with the member, their family or caregiver, and their providers to create and maintain an individualized care plan that reflects the member's physical, mental, and social needs and preferences. Care coordination services are delivered through multiple levels of support, including basic care management, care coordination, complex care management, and through California Integrated Care Management (CICM), which supports the most vulnerable members.

In addition to coordinating medical and behavioral health care, the care team also facilitates timely referrals to address social drivers of health (SDOH), such as food insecurity, housing instability, and transportation needs. Members may also be connected to long-term services and supports (LTSS), community-based organizations, and educational materials tailored to their conditions and care goals. Through proactive outreach, timely referrals, and regular review by the Interdisciplinary Care Team (ICT), care management helps coordinate services across Medicare and Medi-Cal benefits. This process supports early identification of health concerns, improves transitions of care, and helps reduce preventable emergency visits and hospital admissions. Providers play an essential role by collaborating with the care team, sharing updates about the member's condition, and participating in care plan development and ICT meetings as appropriate. Together, these efforts aim to deliver seamless, whole-person care that improves outcomes and quality of life for CenCal CareConnect members.

As part of the care management process, the care team performs a comprehensive assessment of each member's current health status, functional abilities, and social needs. This assessment helps identify resource needs, gaps in care, and potential risk factors. Based on the assessment, the care team develops an individualized care plan and conducts ongoing monitoring and follow-up to address changes in the member's condition and ensure continued access to needed services and supports. Care management is available to all CenCal CareConnect members, with a particular focus on supporting the most vulnerable populations, including those with complex medical, behavioral health, and social needs.

Description of the CenCal CareConnect (D-SNP) Population

The dual eligible population is characterized by the following:

- Eligible to participate in CenCal CareConnect.
- Demographic characteristics, social factors, cognitive factors, environmental factors, living conditions, and co-morbid conditions of CenCal CareConnect members.

- Health conditions impacting CenCal CareConnect members.
- Unique characteristics of the CenCal CareConnect population.
- Significant barriers that CenCal CareConnect members face.
- Identification of the most vulnerable members of CenCal CareConnect.

Description of CenCal CareConnect Population: Most Vulnerable Members

CenCal Health has identified the following special populations:

- Adults Experiencing Homelessness
- Adults At Risk for Avoidable Hospital or Emergency Department Utilization
    - Readmissions within 30 days or multiple hospitalizations
- Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Adults Transitioning from Incarceration
- Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization
    - Require assistance with multiple ADLs
    - Live alone without family support or caregivers
- Adult Nursing Facility Residents Transitioning to the Community
- Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities, as defined by California public health data on maternal morbidity and mortality (Birth Equity)
- Adults with Documented Dementia Needs
- Members with advanced illness at the end of life seeking palliative care or hospice care
- Adults with three or more chronic conditions or specific complex chronic conditions
- Homebound individuals
- Individuals with Cognitive Impairment
- Food Insecurity
- Low Income
- Social Isolation
- Low Literacy

Description of CenCal CareConnect: Most Vulnerable Members: Specific Population

California Integrated Care Management (CICM)

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state.

Description of CICM Populations

- Adults Experiencing Homelessness
- Adults At Risk for Avoidable Hospital or Emergency Department Utilization
- Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs

- Adults Transitioning from Incarceration
- Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization
- Adult Nursing Facility Residents Transitioning to the Community
- Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic. Disparities as defined by California public health data on maternal morbidity and mortality (Birth Equity)
- Adults with Documented Dementia Needs

Adults Experiencing Homelessness
For members experiencing homelessness, an in-person visit is required.

Referrals
All CenCal CareConnect members are enrolled in Care Management. Members are identified each month on enrollment and eligibility reports. Care Managers, Social Workers, Behavioral Health, Primary Care Providers, Specialists, and other ancillary departments can refer a CenCal CareConnect member for Care Management needs.

For Care Management referrals and assistance, contact the Health Services Central Line at 805-562-1082 for assistance.

This section applies to the following CenCal Health programs:

Medi-Cal

I4: Pediatric Whole Child Model

The Pediatric Whole Child Program has dedicated nurses, social workers, and non-clinical professionals who assist providers with timely processing of necessary specialty referrals and service requests, as well as provide care coordination and care transition services to members. It is a program that serves as a comprehensive, centralized resource that enables providers to access covered services for children and youth under the age of 21. The Pediatric team is comprised of a group of specialized staff who perform both utilization review and case management activities. Like CenCal Health's Adult Case Management Program, pediatric care coordination and care transition services are dependent on active family and/or caregiver participation.

The Pediatric team processes, facilitates, and/or coordinates:
a. Referrals (RAF)
b. Prior authorization requests (50-1, 18-1, 20-1)
c. Care management and support of social determinants of health
d. Care coordination with specialized agencies such as CCS, TCRC, LEA, etc.
e. Linkage to community resources
f. Transition planning to adulthood

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

I5: Community Supports

Community Supports are medically appropriate and cost-effective alternative services. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations. Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible members. Community Supports address the health-related social needs of CenCal Health members, helping them stay healthy and avoid costly care. Services include housing support, caregiver respite, and access to nutritious meals during health events. Typically delivered by community-based organizations, these supports may also be provided by ECM providers with relevant experience.

Community Supports are optional services for CenCal Health to offer and are optional for members to receive. CenCal Health has elected to offer the following Community Supports:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Medically Tailored Meals/Medically Supportive Foods
- Sobering Centers
- Recuperative Care (Medical Respite)
- Day Habilitation Programs
- Respite Services
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Transitional Rent

Members Eligible to Receive Community Supports

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

To learn more about the eligibility criteria for each Community Support, please visit www.cencalhealth.org/providers/calaim/.

Making a Referral for Community Supports

Referrals for Community Supports may be made by a physician, a CenCal Health member or a member's family, legal guardians, Authorized Representatives (ARs), or caregivers. Referrals may also be made by a community service agency, a hospital or health care provider, or an ECM or Community Supports provider.

Community Supports Information and Referral Forms are on CenCal Health's website:
www.cencalhealth.org/providers/community-supports/
https://www.cencalhealth.org/providers/calaim/

Community Supports Authorizations

Authorization through CenCal Health is required for members to obtain Community Supports. To determine program eligibility, CenCal Health staff reviews the referral form associated with the specific Community Support service, along with other available data sources, including social determinants of health. If approved after CenCal Health's determination, the member may receive Community Supports. Some Community Supports, such as housing deposits, are limited to once per lifetime.

This section applies to the following CenCal Health programs:

CenCal CareConnect (HMO D-SNP)

I6: Model of Care

Overview

The Centers for Medicare & Medicaid Services (CMS) requires that all Medicare Advantage Special Needs Plans (MA-SNPs) have a Model of Care (MOC). The D-SNP Model of Care serves as CenCal CareConnect's framework for describing how CenCal Health will address the unique needs of its members through care management policies, procedures, and operational systems. There are four core elements of the CenCal CareConnect Model of Care, including:

- Description of the overall D-SNP population
- Care coordination
- Provider network
- Quality measurement and performance improvement

Description of the CenCal CareConnect (D-SNP) Population

The CenCal CareConnect (D-SNP) population is characterized by the following:

- Eligible to participate in CenCal CareConnect plan.
- Demographic characteristics, social factors, cognitive factors, environmental factors, living conditions, and co-morbid conditions of

CenCal CareConnect members.
- Health conditions impacting CenCal CareConnect members.
- Unique characteristics of the CenCal CareConnect population.
- Significant barriers that CenCal CareConnect members face.
- Identification of the most vulnerable members of CenCal CareConnect.

Description of CenCal CareConnect Population: Most Vulnerable Members

The most vulnerable population subset that CenCal Health expects to serve through our D-SNP, CenCal CareConnect, includes a diverse and high-need population.

CenCal CareConnect has identified the following special populations:

- Adults Experiencing Homelessness
- Adults At Risk for Avoidable Hospital or Emergency Department Utilization
- Readmissions within 30 days or multiple hospitalizations
- Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Adults Transitioning from Incarceration
- Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization
- Require assistance with multiple ADLs
- Live alone without family support or caregivers
- Adult Nursing Facility Residents Transitioning to the Community
- Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities as defined by California public health data on maternal morbidity and mortality (Birth Equity)
- Adults with Documented Dementia Needs
- Members with advanced illness at the end of life seeking palliative care or hospice care
- Adults with three or more chronic conditions or specific complex chronic conditions
- Homebound individuals
- Individuals with Cognitive Impairment
- Food Insecurity
- Low Income
- Social Isolation
- Low Literacy

Description of CenCal CareConnect: Most Vulnerable Members: Specific Population

California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state.

Description of CICM Populations

- Adults Experiencing Homelessness
- Adults At Risk for Avoidable Hospital or Emergency Department Utilization

- Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Adults Transitioning from Incarceration
- Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization
- Adult Nursing Facility Residents Transitioning to the Community
- Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities as defined by California public health data on maternal morbidity and mortality (Birth Equity)
- Adults with Documented Dementia Needs

Adults Experiencing Homelessness

For members experiencing homelessness, visits must be provided in person.

Care Coordination

Care coordination is defined as the following:

- **CenCal CareConnect Staff Structure**: Administrative and clinical roles specific to CenCal CareConnect members.
- **Health Risk Assessment Tool (HRA):** Assessment of the CenCal CareConnect member's health needs.
- **Face-to-Face Encounter:** In person or an interactive telehealth visit involving the CenCal CareConnect member and a participant of their Interdisciplinary Care Team.
- **Individualized Care Plan (ICP):** A plan of care for the CenCal CareConnect member based on information from the HRA.
- **Interdisciplinary Care Team (ICT):** A team of medical, behavioral, and ancillary providers, plus the CenCal CareConnect member and an authorized representative.
- **Care Transition Protocols:** Guidelines on how to manage the CenCal CareConnect member across the care continuum.
- **CICM (Medi-Cal ECM-like):** Care management coordination provided through the CenCal CareConnect program.

Care Coordination: Staff Structure and Roles

CenCal CareConnect staff is organized to align with essential care management roles:

- Administrative staff
- Clinical staff

Administrative Roles

CenCal CareConnect administrative roles manage:

- Enrollment
- Eligibility
- Claims
- Grievances and provider complaints
- Information communication

- Collection, analysis, and reporting of performance and health outcomes data

Clinical Roles

CenCal CareConnect clinical roles:

- Direct and oversee member care
- Provide education on self-management techniques
- Perform care coordination
- Provide pharmacy consultation
- Provide behavioral health counseling

Care Coordination: HRA

CenCal CareConnect HRA:

- CenCal CareConnect administers an initial (90-day) and an annual HRA for each member.
- CenCal CareConnect uses a standardized HRA tool.
- HRA is used to evaluate medical, functional, cognitive, psychosocial, and mental health needs.
- Results are used to develop the member's ICP.
- HRA may be face-to-face, telephonic, electronic, or paper-based.
- HRA identifies care needs that are categorized into care domains: Physical Health, Behavioral Health, Long-Term Services and Supports (LTSS), Access to Care, Caregiver support, Care Coordination, and promotion of Self-Management/Health and Wellness Monitoring.

Care Coordination: Face-to-Face Encounter

The face-to-face encounter is conducted in person. It is also available via an interactive telehealth visit based on the preference of the member. The PCP is primarily accountable for face-to-face encounters. The member's PCP or specialist serving as the PCP, and members of the enrollee's ICT, care management, and care coordination staff can conduct the face-to-face encounter for the delivery of health care services. The face-to-face encounter, at a minimum, involves the CenCal CareConnect member and a participant of their ICT or CenCal CareConnect's case management team or designee.

Care Coordination: Individualized Care Plan

CenCal CareConnect ICP:

- The ICP is the person-centered plan of care that incorporates the member's specific physical health, behavioral health, functional needs, cognitive functioning, social health, support system, resource needs, and personal health care preferences.
- The ICP includes prioritized, personalized, and measurable goals to meet a member's specific needs.
- The ICP comprehensively integrates information from the HRA, the member's risk care level, historical utilization and case management

data, comprehensive assessments, LTSS/Community Supports, identified barriers to care, and the member's main health concern to develop the plan of care.
- The ICP goals will be reassessed at least annually, upon identification of changes in the member's health care status or to address barriers to meeting care planning goals.
- CenCal CareConnect Care Management supports the development, implementation, and ongoing monitoring and modification of a member's ICP through an ICT process, in conjunction with the member and/or their caregiver and providers.
- The ICP is maintained in the clinical documentation platform.
- The ICP is considered part of the member's care management record and stored in accordance with HIPAA and in compliance with state, federal, and HIPAA requirements.
- The ICP is shared with the member, PCP, and applicable participants of the ICT initially and as part of the member's ongoing care and coordination when applicable.

Care Coordination: Interdisciplinary Care Team

Care Management support for ICT:

- Facilitates the participation of the member, their caregiver, or authorized representative in the development of their ICP.
- Supports the member's right to self-direct care.
- Ensures the member's holistic needs are identified.
- Facilitates linkage to appropriate LTSS.
- Improves member/provider engagement, satisfaction, and communication.
- Prevents duplication of services.
- Prevents transition to a higher level of care.
- Closes gaps in care through communication with the ICT participants.

The ICT is a structured collaborative process that includes the PCP, case manager, and other disciplines, as appropriate.

- All members receive informal ICTs with all applicable ICT participants contributing to the development and coordinating the implementation of the ICP.
- All coordination and communication are documented in the clinical documentation platform, and the ICP is updated accordingly.
- Formal ICT meetings will be held and include all applicable ICT participants as appropriate for requesting members or PCP; members stratified as high-risk, and members identified in a vulnerable population.
- Formal ICT meeting core participants can include the member, PCP, case manager, social worker, care coordinator, and medical director.
- Additional participants, such as the behavioral health specialist, clinical pharmacist, dietician, LTSS coordinator, utilization management nurses, facility discharge planners, palliative care team, dementia care

specialists, therapists, and community-based organizations, may be included in the ICT based on the member's specific needs.

Care Coordination: Care Transition Protocols

CenCal CareConnect Transitions Program addresses comprehensive biopsychosocial care needs before, during, and after a transition to prevent readmissions and ensure safe and coordinated care across the care continuum.

Care Coordination: Medi-Cal Enhanced Care Management Like Services - California Integrated Care Management (CICM)

CenCal CareConnect members needing care management services through D-SNPs may also meet the criteria for the Medi-Cal ECM-like Population of Focus. CenCal CareConnect members who meet the criteria for the Medi-Cal ECM Population of Focus will be offered ECM-like services through CICM care management services, provided through CenCal CareConnect, to streamline coordination to a single point of contact and eliminate duplication of effort if a member receives both programs.

Provider Network

The CenCal CareConnect Provider Network includes:

- Primary Care Providers
- Specialized expertise, such as:
    - Specialists
    - Hospitalists
    - SNF providers
    - Allied health providers
    - Behavioral health providers
    - Community-Based Adult Services
    - Multipurpose Senior Service Program
    - In-Home Supportive Services
    - Long-term care institutional services
    - Pharmacists
    - Crisis teams
    - Ancillary services
    - Community-based palliative care providers

- Facilities, such as:
    - Acute inpatient facilities, including behavioral health
    - Dialysis centers
    - Post-acute hospital facilities, including SNFs and long-term care
    - Specialty outpatient clinics
    - Residential care facilities
    - Rehabilitation facilities
    - Radiology and imaging facilities
    - Laboratory facilities
- Providers who are part of the care team will collaborate with the ICT as applicable.

- Use of evidence-based clinical practice guidelines and established care transition protocols to promote consistent, coordinated, and high-quality care.
    - Formalize oversight of provider network adherence to nationally recognized care standards.
- CenCal CareConnect Model of Care training for the provider network:
    - Assure provision and attestation of initial and annual MOC training.

CenCal CareConnect Provider Network

CenCal CareConnect Provider Network includes:

- Contracting with board-certified providers.
- Monitoring network providers to assure they use nationally recognized clinical practice guidelines.
- Assuring that network providers are licensed and competent through a formal credentialing review.
- Having a broad network of specialists, including palliative care, pain management, chiropractors, and psychiatrists.
- Monitoring network adequacy to ensure access to care.

Quality Measurement and Performance Improvement

Quality measurement (QM) and performance improvement (PI) are evaluated by:

- MOC Quality Performance Improvement Plan.
- Measurable goals and health outcomes for the MOC.
- Measuring patient experience of care (SNP member satisfaction).
- Ongoing performance improvement evaluation of the MOC.
- Dissemination of SNP quality performance related to the MOC.

Performance Measurement

CenCal CareConnect uses standardized quality improvement measures of performance and health outcomes, such as:

- Healthcare Effectiveness Data and Information Set (HEDIS).
- Disease management measures.
- Utilization management measures.
- Member and Provider satisfaction surveys (CAHPS, HOS).
- Ongoing monitoring of complaints and grievance summaries.
- Care Management Performance (HRA, ICP, ICT, TOC).
- Network Adequacy.
- Tracking and assessing completion of MOC training.

CenCal CareConnect MOC Measurable Goals

CenCal CareConnect evaluates measurable goals that:

- Improve coordination of care and the appropriate delivery of services.
- Reflect appropriate utilization of services for preventive health and chronic conditions.
- Improve member experience.

- Enhance care transitions across all health care settings and providers.

Measurement of Effectiveness

CenCal CareConnect measures MOC effectiveness by collecting and reporting data on:

- Improvement in access to care.
- Improvement in member health status.
- Staff implementation of MOC.
- Comprehensive HRA.
- Implementation of ICP.
- Provider network of specialized expertise.
- Application of evidence-based practice.
- Improvement of member satisfaction and retention.

CenCal CareConnect Clinical Guidelines

CenCal CareConnect supports the physician management of chronic conditions by dissemination of best practices, evidence-based guidelines, and provider toolkits to promote education and adherence.

Summary

The Model of Care (MOC) outlines CenCal CareConnect's comprehensive approach to meeting the unique needs of dual-eligible members. It serves as a framework for coordinating care across Medicare and Medi-Cal benefits through interdisciplinary care teams, individualized care planning, and proactive outreach. The MOC focuses on improving health outcomes, enhancing quality of life, and reducing preventable hospitalizations by addressing members' medical, behavioral, and social needs through person-centered care management.

- Setting organizational-wide strategic goals to improve quality, coordination, and member outcomes.
- Contracting with a network of qualified and specialized providers to meet diverse care needs.
- Striving to address each member's unique medical, psychosocial, functional, and cognitive needs through individualized care planning.
- Coordinating services across Medicare and Medi-Cal benefits to reduce fragmentation and improve access.
- Engaging an interdisciplinary care team to regularly review and update care plans.
- Promoting proactive outreach, timely referrals, and early intervention to help prevent avoidable hospitalizations and emergency room visits.

Section J: Disease Management Programs

This section applies to the following CenCal Health programs:

Medi-Cal

J1: Disease Management Programs Addressing Chronic Diseases

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

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

a. Asthma
b. Cardiovascular disease
c. Diabetes
d. Depression
e. Maternal mental health

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

- CenCal Health additionally provides targeted disease management interventions and support for members with a diagnosis of asthma, cardiovascular disease, or diabetes with a recent ED visit or hospital admission.

All programs provide a comprehensive, ongoing, and coordinated approach to achieving desired health outcomes and seek to close care gaps for members participating in the interventions to improve health equity and reduce health disparities. CenCal Health disease management programs help facilitate patients' care and also offer support to care providers.

Benefits include:

a. Access to patient-specific condition monitoring.
b. Collaboration to support treatment plan.
c. Assistance in educating patients on self-management (which includes prevention of disease exacerbation and complications).
d. Use of evidence-based practice guidelines in program content.

CenCal Health members who qualify for disease management program support are enrolled in these programs and may opt out of the program at any time. Interventions are based on severity level and include, but are not limited to:

a. Enhanced health education for all members (welcome packet containing health education and program information).

b. Telephonic health coaching from a nurse.
c. Care coordination support.
d. Community resource referrals.

If you would like to refer a new patient or confirm that a patient is in the program, call the CenCal Health Case Management Department at 805-562-1082.

Section K: Claims and Billing Guidelines

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

K1: Claims Billing

CenCal Health follows the guidelines and benefits outlined in the Medi-Cal manuals or other guidance published by DHCS; relevant DHCS agreements; and the guidelines and benefits outlined in the Medicare manuals published by CMS. Please see the Benefits and Exclusions section for specific programs found in the Benefits Summary section of this Provider Manual. For specific claim questions, you may contact our Claims Customer Service Representatives. The address and telephone number for the Claims Customer Service team are listed at the end of this section.

CenCal Health will process and pay all claims within the contractually mandated statutory timeframes and in accordance with timely payment standards.

Below is a list outlining the general billing requirements. Bullets apply to all programs, except where specific programs are indicated:

Claims Submission

- Claims may be submitted electronically through a clearinghouse, via the Provider Portal on our website at www.cencalhealth.org, or on a hard copy claim form.

Clean Claims Processing

- A clean claim is a claim that is complete, accurate, and error-free, allowing the health plan to process and pay without requesting additional information.
- CenCal Health will process all claims within the contractually mandated statutory timeframes and in accordance with timely payment standards for "clean" claims, unless otherwise specified in the provider contract.
    - Medi-Cal Claims: DHCS expects health plans to pay "clean" claims within 30 calendar days of receipt, for both Contracted and Non-Contracted Providers.
    - Medicare Claims: CMS expects health plans to pay 95% of "clean" claims for Non-Contracted Providers within 30 days of receipt and 60 days of receipt for Contracted Providers.

Non-Clean Claims Processing

- If the Medi-Cal claim is not clean, the Contracted or Non-Contracted Provider will be notified in writing that the claim or portion thereof is contested or denied, as soon as practicable, but no later than 30 calendar days after CenCal Health receives the claim.
- All Medicare claims from Non-Contracted Providers will be paid or denied within 60 calendar days from the date of the request.

Timely Payment

- For Contracted Providers, Medi-Cal claim payment is the lesser of the contracted rate or the provider's billed charges. Payment will not exceed the billed charges unless specifically exempted in the contract.
- For Non-Contracted Providers, Medi-Cal claims are reimbursed at the lesser of the Medi-Cal Fee-For-Service (FFS) rate or the provider's billed charges. Payment will not exceed the billed charges.
- *For Medicare-covered services rendered by Non-Contracted Providers, reimbursement is based on the applicable Medicare fee schedule. Any applicable Medi-Cal cost-sharing liability will be coordinated in accordance with Medicare and Medi-Cal requirements. Total reimbursement will not exceed the provider's billed charges unless specifically stated in the provider agreement.*

Late Payment Interest and Penalties

- For Contracted and Non-Contracted Providers, Medi-Cal Clean Claims that are not paid within the required timeframe will accrue interest.
- For Non-Contracted Providers, Medicare Clean Claims that are not paid within the required timeframe will accrue interest.
- For Contracted Providers, Medicare claim payment is payable at the contracted rate. Payment timeliness, prompt payment requirements, and any applicable interest obligations are governed by the provider agreement. Payment will not exceed the billed charges unless specifically stated in the provider agreement

Member administrative fees or surcharges

Under no circumstances whatsoever may a provider collect or attempt to collect fees from a CenCal Health member (Medi-Cal or CenCal CareConnect beneficiary) for any non-clinical or administrative services, including but not limited to fees for: enrollment or subscription, appointment access, filling out forms or prescriptions, or for late arrival or absence from an appointment (also known as "no-show" fees), or collect Medicare cost-sharing amounts for Parts A and B services.

Providers must refer any CenCal Health member who is habitually late or absent from appointments to CenCal Health's Member Services Department. CenCal Health will follow up with the member and provide any education or outreach needed. Providers must immediately return any such collected fees to the member and may be subject to termination from the network for violating this policy. Any such fees not returned to the member may be withheld from future claim payments to the provider. Providers can also find information regarding member limits of cost-sharing liability on the Explanation of Payments (EOP) and CenCal Health's Provider Portal.

Providers may not discriminate against members based on their payment status or refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a state Medicaid program.

Ambulatory Surgery Centers and Surgical Implant Billing
For Ambulatory Surgery Center (ASC) facilities in the CenCal Health network that are paid according to Medicare rates, it is acknowledged that Medicare typically bundles in the value of surgical implants to the global facility fee paid to ASC facilities. The ASC fee thus includes the cost of those surgical implants.

CenCal Health has identified a list of surgical Implant Procedures (below) involving the use of implanted devices and associated supplies, whose value is included in the Medicare ASC fee schedule rate paid by CenCal Health, including but not limited to:

Implant Procedure	Associated CPT Procedure Codes
Joint Replacement Surgery	27446, 27447
Pacemakers	33206, 33207, 33208, 33212, 33213, 33214, 33221, 33227, 33228, 33229
Defibrillators	33230, 33231, 33240, 33249, 33262, 33263, 33264, 33270, 33271
Cardiac Event Recorders	33282
Infusion Pumps	62360, 62361, 62362
Neurostimulators	61885, 61886, 63650, 63663, 63664, 63665, 63685, 64568, 64575, 64580, 64581, and 64590
Cochlear Implants	69930

Implants and supplies billed by ASC facilities in conjunction with the above Implant Procedures are not eligible for separate reimbursement if the facility is reimbursed at Medicare rates. The Associated CPT Procedure Codes are provided as a reference – any changes to CPT codes associated with the Implant Procedures described above may be incorporated into this policy at any time, at the sole discretion of CenCal Health.

Whole Child Model (WCM) and California Children's Services (CCS)
Effective July 1, 2018, CenCal Health assumed the responsibility of both Santa Barbara and San Luis Obispo counties for the Utilization and Claims payment for CCS-eligible members who reside in these counties. Providers must be CCS certified for the specialty services they provide.

Standard CenCal Health claim submission, claim correction, dispute/appeal, and timely filing requirements as outlined elsewhere in the Provider Manual and on our website also apply to claims for CCS services rendered to CenCal Health members.

Baby/NICU services may need to be billed using the mother's Member ID for the first two months of life, beginning with the month of birth, and to ensure the correct

relationship code is utilized.

Please visit the CenCal Health website for additional Claims and Billing Guidelines or the Medi-Cal Manual.

Denied Claims

Providers are requested to review the denial explanation code(s), correct the issue(s), and rebill the claim for further consideration of payment. CenCal Health must receive any corrections within six months from the date of the Explanation of Payment on which the claim originally appeared. Any corrections received after the end of the sixth month will not be considered.

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

Prohibited Claims

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

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

Recovery from third-party sources for Medi-Cal Covered Services rendered to a member may be allowed, to the extent that such member is covered for such services under any other state or federal medical care program or under other contractual or legal entitlement, including but not limited to, a private group or individual indemnification program. However, recovery shall not be attempted in circumstances involving casualty insurance, tort liability, or workers' compensation. Circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation awards shall be reported to DHCS within 10 days after discovery.

Disputes

If you do not agree with any decision made by CenCal Health with respect to payment or denial, you may dispute the decision. Submit a Dispute Form with all the information, including any attachments/documentation, for consideration of payment within six months of the initial EOP date. The appropriate staff member will review your dispute, and you will be informed of the decision, in writing, within 45 working days of receipt of the dispute. This applies to all CenCal Health programs.

Appeals
An appeal may be submitted to contest the processing, payment, or non-payment of a previously submitted dispute. Providers must submit in writing within 90 days of the action/inaction precipitating the complaint. Failure to submit an appeal within this 90-day period will result in denial of the appeal.

Contact Information for Claims

Submit Original Claims to:
CenCal Health
P.O. Box 948
Goleta, CA 93116-0948

Send Claim Disputes and Appeals:
CenCal Health
Attention: Claims Department
4050 Calle Real
Santa Barbara, CA 93110-3445

Telephone Claim Inquiries:
805-685-9525, ext. 1083
800-421-2560, ext. 1083

Email Inquiries:
cencalclaims@cencalhealth.org

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

K2: Payment Procedures for CenCal Health Members

Billing and Payment for Inpatient Services
A day of service is billed and reimbursed for each member who occupies an inpatient bed at 12 a.m. (midnight) in the hospital facility. Regarding a newborn, the mother's ID number may be used for the baby for the month of birth and through the end of the second month following birth. Once a newborn is assigned their own Medi-Cal identification number, that number will be used on all future claims, and the mother's ID can no longer be submitted.

Hospitals should not separately bill for outpatient, urgent care, and emergency services provided to a member within 24 hours of the admission of the member to hospital when the foregoing services are directly related to the condition(s) for which the member is admitted to hospital.

Providers may have multiple taxonomy codes; it is important to select the code that most accurately reflects the specialty rendering the service. Claims should include Taxonomy codes for both the rendering and billing provider, as applicable.

Claims Submission Timeliness

Providers shall bill CenCal Health for medical services on the UB-04 or its successor, on the CMS-1500 or its successor, or in an electronic format using industry standards as specified by CenCal Health and/or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to qualify for full payment, providers should submit the claim to CenCal Health within 180 days from the date of service. For the Medi-Cal program, claims received in the 7th to 9th month from the date of service will be paid at 75% of the allowable, and claims received in the 10th to 12th month from the date of service will be paid at 50% of the allowable.

Claims submitted one year after the date of service will not be considered without a valid reason for the delay and supportive documentation. Please refer to the Medi-Cal manual for the usage of the delay reason code(s) when submitting a claim after one year from the date of service.

Providers shall comply with existing state and federal law and regulations pertaining to the issuance of explanations of payment (EOPs) for CenCal Health members. Additional information on EOPs can be found in the Claims Section of this Provider Manual.

Providers shall be aware that any other health program (including Medicare) must be billed and recoveries made prior to billing state programs. Such rules shall also apply to CenCal Health's administration of the Medi-Cal program. If CenCal Health receives a claim and determines that another insurance has been, or should have been billed, CenCal Health shall process such claims, reduce payment, or deny claims as appropriate, with notice of such reduction or denial indicated on the EOP. See the proceeding section on Other Health Coverage, Section K3 of the Provider Manual.

Claims Processing

CenCal Health will receive and process a clean claim in a timely manner and according to standards set forth in the Provider Services Agreement, the Medi-Cal and Medicare guidelines, and benefits outlined in the manuals published by the Department of Health Care Services (DHCS) and The Centers for Medicare & Medicaid Services (CMS), or in this Provider Manual.

Payment Requirements/Responsibilities with the Prudent Layperson Standard for Emergency Services

The determination of whether the prudent layperson standard was met, as defined in the definition of Emergency Services, is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following: placing the patients' health in serious jeopardy; serious impairment to bodily

functions; serious disfunction to any bodily organ or part, and in the Medically Necessary Services section of this Provider Manual will be made on a case-by-case basis.

CenCal Health may not deny coverage solely based on diagnosis code(s), nor deny coverage and then require submission of the claim as part of an appeal process. Prior to denying coverage or modifying a claim for payment, CenCal Health will determine whether the prudent layperson standard has been met on the basis of all pertinent documentation, with focus on the presenting symptoms (and not on the final diagnosis). Additionally, CenCal Health will take into account that the decision to seek Emergency Services was made by a prudent layperson (rather than a medical professional).

Emergency Room, Urgent Care, and Treatment/Exam Room Claims Processing

Providers should follow the general guidelines as indicated in the Claims Section of this Provider Manual when billing these claim types.

Inquiries and Appeals Regarding Claims Processing and/or Payment

If the provider has an inquiry or an appeal concerning the processing or payment of its claims by CenCal Health for services provided, CenCal Health has established procedures to accommodate the provider's desire to have its inquiry or appeal evaluated and resolved.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

K3: Other Health Coverage (OHC)

Other Health Coverage (OHC) refers to private health insurance. Services may include medical, mental health, dental, vision, pharmacy, and/or Medicare supplemental plans (Part C & D). A person covered under CenCal Health may also have other private/group health insurance. Having private/group health insurance does not affect a member's Medi-Cal eligibility in any way.

However, if you are not a participating provider of a recipient's OHC, you should advise the member to obtain services through their other insurance or Health Maintenance Organization (HMO) Primary Care Provider (PCP) or refer them to a provider who participates in that plan. For instance, if you are the member's PCP through CenCal Health but not the member's PCP through Blue Cross HMO, you should refer the member to their Blue Cross HMO or obtain a treatment authorization from the HMO. CenCal Health will not reimburse for services not authorized by the Primary Insurance. If you are not an authorized provider of the recipient's Primary Insurance, please refer the member to their primary health plan and/or ask the member to contact the CenCal Health Member Services Department to reselect a PCP who participates in both programs.

Federal and state laws require both Medicare and Medi-Cal beneficiaries to report OHC to ensure the proper coordination of benefits and that Medi-Cal is the payer of last resort. This means in most cases Medi-Cal will be secondary or sometimes even tertiary to the OHC, covering allowable costs not paid by the primary (and secondary) insurance up to the Medi-Cal rate. When CenCal Health learns that a beneficiary has OHC, the Medicare and/or Medi-Cal record is then updated to reflect the OHC.

To report an OHC error or request an update to a member's OHC record, please follow the steps outlined below:

a. Report all OHC/Medicare updates to the Recoveries Department at recoveries@cencalhealth.org or through the member portal.
b. For OHC adds, we will need the following information:
    a. Name of the insurance company,
    b. Policyholder name,
    c. DOB,
    d. Policy number and effective date.
c. For OHC terms: We will need a termination letter from the insurance company showing policy number and termination date. This will be attached to member records.
d. If policies can't be verified, we will also accept a written statement from the members.
e. All insurances will be verified and sent to DHCS for updates.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

K4: Billing for Members Who Have Other Coverage

This section applies to Medi-Cal:

State law mandates Medi-Cal to be the payer of last resort, and requires the utilization of other available healthcare coverage prior to the utilization of Medi-Cal. Other coverage is always the primary payer and cannot be waived by the member. We ask that you always bill the member's other coverage first, prior to billing CenCal Health. If the other coverage denies payment, a copy of the Explanation of Payment (EOP) or denial letter must be sent with your claim to CenCal Health. A list of services that can be billed directly to CenCal Health can be found in the Medi-Cal manual section under Other Health Coverage (OHC): CPT® and HCPCS Codes

Providers are required to notify CenCal Health if they believe a member may be entitled to health coverage through a private/group health insurance plan or policy that is not indicated on the member's eligibility record. Providers should call CenCal Health's Finance Department, Recoveries Unit at 805-562-1081 to report possible other insurance coverage. Providers are prohibited from billing members other insurance copayment amounts for Members with Other Coverage.

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

If the member has other health coverage, claims must be received within 60 days from the date of the EOP from the other health carrier and within one year from the date of service to be considered for full payment. Claims received after 60 days from the EOP date fall back to Medi-Cal Submission and Timelines guidelines.

CenCal Health will reimburse the provider up to the Medi-Cal allowable, less the other health coverage payment, but will not exceed the member's coinsurance. CenCal Health will not pay the balance of a provider's bill when the provider has an agreement with the other health coverage to accept its contracted rate as "payment in full."
If the recipient elects to seek services not covered by CenCal Health, CenCal Health is not liable for the cost of those services.

This section applies to CenCal CareConnect:
CenCal Health's CareConnect is a D-SNP health plan for people who qualify for both Medicare and Medi-Cal. Claims submitted by the provider are first adjudicated by CenCal Health against the Medicare benefit as the primary benefit.

Subsequently, CenCal Health's claims processing system coordinates benefits against the Medi-Cal benefit. Providers are not required to submit a second claim to CenCal Health in order to coordinate the Medicare payment with Medi-Cal. This is done automatically by CenCal Health.

Claims for services where there is no Medicare benefit (example: hearing aids) are denied under the Medicare claims adjudication process and are processed as a Medi-Cal claim under the Medi-Cal benefit package.

In some instances, benefits received under the CenCal CareConnect line of business are secondary. Another insurance may be primary when the member has:

a) Group health insurance
b) COBRA
c) Liability insurance when services are related to an accident
d) Workers' compensation service related to a workers' compensation injury
e) VA authorized services
f) Tricare or
g) FBLBP (Black Lung Program)

Reference Link:
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/05E2EDA7-E291-4916-92A6-CC0DA50C4D70/othhlthcpt.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

K5: What You Should Know About Non-CenCal CareConnect Medicare Advantage Plans

The Other Health Coverage code "F" identifies Medi-Cal members who receive benefits from Medicare-contracted Health Maintenance Organizations (HMO) in lieu of the fee-for-service Medicare plan. Members who have both Medi-Cal coverage and Medicare HMO coverage must first seek medical treatment through the Medicare HMO. CenCal Health will not pay for the services if the patient elects to go to a provider who is not participating with the primary plan for care. However, CenCal Health will reimburse for services that are Medi-Cal-covered benefits but not covered by the Medicare HMO plan.

Medi-Cal claims for members with Medicare HMO coverage may not be Medicare/Medi-Cal crossover claims (see below). Therefore, to bill Medi-Cal for services not included in the Medicare HMO plan, submit a Medi-Cal claim accompanied by a Remittance Advice (RA), Explanation of Medicare Benefits (EOMB), or denial letter showing that the Medicare HMO was billed first.

This section applies to the following CenCal Health programs:

Medi-Cal

K6: Medicare/Medi-Cal Crossover Claims

Claims for members who are eligible for both Medicare and Medi-Cal coverage must be billed to Medicare (either electronically or on paper) prior to billing Medi-Cal, with the exception of Medicare non-covered services. A list of Medicare Non-Covered Services can be found in the Medi-Cal manual section under Medicare Non-Covered Services: CPT Codes (medi non cpt) and Medicare Non-Covered Services: HCPCS Codes (medi non hcp). CenCal Health may reimburse providers for the Medicare deductible and coinsurance. A claim for Medicare deductible and coinsurance amounts is called a crossover claim.

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

The California Welfare and Institutions Code (WIC) limits Medi-Cal payments of the deductible and coinsurance to an amount that, when combined with the Medicare

payment, should not exceed the amount paid by Medi-Cal for similar services. The combined Medicare/Medi-Cal payment of a claim may not exceed the amounts allowed by CenCal Health.

Providers who accept a patient who is eligible for both Medicare and Medi-Cal cannot bill the member for the Medicare deductible and coinsurance amounts; these amounts can be billed to CenCal Health. However, the provider should bill the patient for their share of cost, if any. Providers are encouraged to wait until they receive the Medicare payment prior to collecting the share of cost to avoid collecting amounts greater than the Medicare deductible and/or coinsurance.

Please note: CenCal Health lifted the Referral Authorization Form (RAF) requirement for crossover services. RAFs are still required for non-Medicare benefits for which Medi-Cal will be the primary payer.

Claims submitted to Medicare electronically will automatically cross over to CenCal Health for processing. These claims should appear on your EOP within 30 days of receipt. If your claim has not appeared on an EOP within this timeframe, you can check the status of your claim via the Provider Portal or resubmit your claim with the Medicare EOB/remittance advice for processing. For further assistance, please contact your Claims Service Representative at 805-562-1083.

If you have any questions about what other coverage a member has, what carrier to bill first, Other Health Coverage codes, or third-party coverage questions, please contact the Recoveries Unit at 805-562-1081.

Reference Links:

Medicare Non-Covered Services: CPT Codes
Medicare Non-Covered Services: CPT® Codes (medi non cpt)

Medicare Non-Covered Services: HCPCS Codes
Medicare Non-Covered Services: HCPCS Codes (medi non hcp)

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

K7: Recoveries of Overpayments to Providers

This section applies to both Medi-Cal and CareConnect
CenCal Health requires Network Providers to report when they have received an overpayment, to return the overpayment to CenCal Health within 60 calendar days

after the date on which the overpayment was identified, and to notify CenCal Health in writing of the reason for the overpayment.

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

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

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

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

This section only applies to CenCal CareConnect

Per CMS Medicare Learning fact sheet MLN006379, an overpayment occurs when a provider is paid more than the amount due and payable according to existing laws and regulations. Identified overpayments are debts owed to the federal government. Laws and regulations require us to recover overpayments.

Through reasonable diligence, a provider can identify any overpayment and calculate the amount. According to Section 1128J(d) of the Social Security Act, a provider must report and return a self-identified overpayment to CenCal Health within:

- 60 days of identifying the overpayment.
- Six years of getting an overpayment, generally known as the "lookback period."
- A corresponding cost report due date, if applicable.

When a provider gets an overpayment of $25 or more, CenCal Health initiates the overpayment recovery process by sending a demand letter requiring repayment.

For self-identified and reported overpayments, after CenCal Health processes a claim, it sends an electronic remittance advice or a standard paper remittance with final claim adjudication and payment information. If you discover an overpayment, you're responsible for returning it to CenCal Health. When returning the self-identified overpayment, explain what caused it and supply the following information for accurate identification:

- Name and Member ID#
- Dates of Service
- Claim #
- Overpaid Amount
- Overpayment Reason/Explanation

If the overpayment is due to a violation of the physician self-referral law, report it through the Self-Referral Disclosure Protocol.

For overpayments we identify, providers may request one of the following repayment methods after you get a demand letter requiring repayment of an overpayment:

- **Immediate Recoupment:** You may request immediate recoupment for all current and future overpayments that occur or make a one-time request for a specific overpayment. Unless you specify it as a one-time request, the immediate recoupment request applies to all current and future debts. Upon your request, CenCal Health recovers an overpayment by offsetting future payments to satisfy the overpayment amount. Generally, CenCal Health classifies written requests for an immediate recoupment as voluntary repayments. If you make an immediate recoupment, it isn't subject to interest under Section 935(f)(2)(B) of the Medicare Modernization Act.
- **Standard Recoupment**: CenCal Health automatically begins standard recoupment according to the schedule in the table below. If the debt becomes delinquent, interest may accrue.
- **Extended Repayment Plan (ERS)**: If you can't make the full overpayment in the required timeframe, ERS will provide instructions for making this request in CenCal Health's demand letter.
- **Rebuttal**: You may submit a rebuttal within 15 calendar days from the date of CenCal Health's demand letter. Your rebuttal must explain and provide evidence about why CenCal Health shouldn't recoup the payment. CenCal Health will promptly evaluate your rebuttal statement.
    - **Note**: A rebuttal differs from an appeal and does not stop recoupment activities.
- **Appeal**: If you disagree with an overpayment decision, you can request an appeal.

Timeframe	**Activity**
Day 1	CenCal Health sends an overpayment determination demand letter within seven calendar days.
Day 15	The last day you can submit a rebuttal.
Day 16	CenCal Health begins immediate recoupment by Day 16 if you request it.
Day 16	CenCal Health begins standard Part A overpayment recoupment, not subject to recoupment limitations or in an excluded category.
Day 30	The last day to pay in full to avoid interest accrual. Interest continues to accrue for each 30-day period until you pay the debt in full. If you request a redetermination on an overpayment that's subject to the recoupment limitation provision, file the redetermination request by Day 30 from the date of the demand letter to prevent recoupment starting on Day 41. If you file an appeal after Day 30, then by Day 120, the law requires CenCal Health to stop recoupment, subject to recoupment limitation when it gets and validates your appeal. In this case, CenCal Health won't refund money they have already recouped until the redetermination process is adjudicated.

Day 31	Interest accrual begins for unpaid overpayments by Day 30, regardless of whether you've filed an appeal or a request for redetermination.
Day 40	The last day you can pay overpayments in full before we begin recoupment, subject to recoupment limitations.
Day 41	CenCal Health begins standard overpayment recoupment unless the overpayment is under an excluded category (for example, overpayments subject to recoupment limitation in the redetermination appeal status).
Day 61-90	CenCal Health sends an intent to refer (ITR) letter for eligible delinquent debts.
Day 90	CenCal Health attempts to call you if the debt is 60 days delinquent and not in a status excluded from referral to the U.S. Treasury Department (the Treasury).
Day 120	The last day you can submit an initial redetermination appeal request.
Day 126 - 150	CenCal Health refers the debt to the Treasury according to timelines specified in the Digital Accountability and Transparency Act.

Reference Links:

APL 23-011
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-011.pdf

MLN006379 October 2023
www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/overpaymentbrochure508-09.pdf

Section L: Quality Management

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

L1: Quality Improvement System

CenCal Health is firmly committed to high-quality, equitable care delivered to our membership in a timely, appropriate, and compassionate manner. The way we ensure this happens is through our Quality Improvement and Health Equity Transformation Program (QIHETP). This program is designed to support CenCal Health's vision *to be a trusted leader in advancing health equity so that our communities thrive and achieve optimal health together***.** The Quality Improvement System complies with state regulations 28 CCR 1300.70, Health Care Service Plan Quality Assurance Program, and federal regulations 42 CFR 438.330, 438.340, and 422.152.

The purpose of CenCal Health's Quality Improvement System is to define a process to continuously evaluate and improve the quality of care, quality of service, patient safety, and member experience provided by CenCal Health and its contracted provider network. The goal is to enhance CenCal Health's ability to deliver high-quality healthcare services and benefits to its Medi-Cal and CenCal CareConnect (D-SNP) members. CenCal Health aligns our goals with the Centers for Medicare & Medicaid Services (CMS) priorities and the California Department of Health Care Services (DHCS) Comprehensive Quality Strategy Goals and Guiding Principles.

QIHETP functions of the organization are overseen by CenCal Health's Board of Directors, which appoints the Quality Improvement Health Equity Committee (QIHEC) as its accountable entity, responsible for the oversight of the QIHETP. CenCal Health's Board of Directors, leadership, and staff ensure implementation of a robust Quality Measurement and Performance Improvement plan to continually monitor performance and drive improvement.

CenCal Health network providers and practitioners cooperate with CenCal Health's quality improvement activities to improve the quality of care and services, patient safety, and member experience. Cooperation includes collaborating with CenCal Health, when requested, in the following activities:

- Performance Monitoring and Reporting
    - Refer to L5: Performance Monitoring and Reporting
- Medical Record Review and Requests
    - Refer to L3: Medical Record Review Process & Requests
- Quality of Care Review
    - Refer to L2: Quality of Care Review Requests

Annually, and in alignment with CenCal Health's Strategic Plan, the Quality Department leads a process to identify and prioritize quality goals. The approach, annual workplan, and evaluation of the previous year's results can be found on CenCal Health's website: Quality Program | CenCal Health Insurance Santa Barbara and San Luis Obispo

Counties. Additionally, the QIHEC quarterly meeting minutes and reports to the Board of Directors are also posted there.

To align both our Medi-Cal and CenCal CareConnect (D-SNP) quality programs, the CenCal CareConnect model of Care (MOC) follows the current QIHETP process, which includes the following quality, patient safety, and member experience areas of focus:

Quality

- Quality of clinical care services
- Quality of nonclinical services
- Network adequacy
- Coordination and continuity of covered services
- Grievance and appeal process
- Information standards

Patient Safety

- Facility site reviews
- Credentialing of practitioners
- Quality of care/peer review
- Coordination and continuity of care (medical and behavioral)

Member Experience

- Satisfaction surveys and assessments
- Member complaints
- Access to care measurement
- Timeliness of member grievance resolution
- Use of culturally and linguistically appropriate services (CLAS)

CenCal Health network providers and practitioners play a functional role in supporting the mission, vision, and values of the QIHETP. This includes routine monitoring of clinical performance using data and resources available in the Provider Portal, staying current with clinical and preventive health guidelines, and participating, as appropriate, in quality improvement activities and the Quality Care Incentive Program (QCIP). For more information on QCIP, refer to L4: Quality Care Incentive Program. For more information on quality improvement activities, refer to L6: Quality Improvement Activities.

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

Reference Links:

CenCal Health's QIHETP

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

CenCal Health's QIHEC Quarterly Reports to CenCal Health's Board of Directors
www.cencalhealth.org/providers/quality-of-care/quarterly-reports/

CenCal Health Care Guidelines
www.cencalhealth.org/providers/care-guidelines/

CFR § 438.340 Managed Care State Quality Strategy

CFR § 438.330 Quality Assessment and Performance Improvement Program

CFR § 422.152 Quality Improvement Program

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

L2: Quality of Care Review Process

CenCal Health is committed to ensuring our members receive appropriate medical care and services. In accordance with Department of Health Care Services (DHCS) contractual obligations, National Committee for Quality Assurance (NCQA) standards and provisions, and Centers for Medicare & Medicaid Services (CMS) requirements, CenCal Health maintains a systematic process to identify, investigate, and evaluate Potential Quality of Care Issues (PQIs). Based on the findings of the investigation findings, CenCal Health determines whether a Quality of Care (QOC) concern exists and identifies any appropriate follow-up actions. CenCal Health also aggregates PQI data to help identify trends and opportunities for improvement within its provider network.

Potential Quality of Care Issue

A PQI is a concern involving a possible deviation from current professional standards of clinical practice, provider performance expectations, or expected outcomes of care. PQIs require further investigation to determine whether a substantiated QOC concern exists.

A QOC concern is a substantiated finding that care or services provided did not meet recognized professional standards, applicable regulations, contractual requirements, or accepted standards of practice. Not all PQIs result in a QOC finding. Each PQI is investigated based on the facts and circumstances of the case to determine whether follow-up action is warranted.

Examples of PQIs may include, but are not limited to:

- Delays in treatment, services, or referrals.
- Concerns related to patient safety or continuity of care.

- Concerns regarding diagnosis, treatment, or clinical decision-making.
- Unexpected adverse outcomes, including unexpected death or procedure-related complications.

PQIs may be identified or reported through multiple sources, including:

- **Member- reported concerns:** Members or their appointed representatives may report concerns by calling CenCal Health's toll-free number at 1-877-814-1861, or by submitting a complaint in person or in writing.
- **External referrals:** PQIs may be reported by contracted providers, community-based agencies, and external partners or liaisons, including California Children's Services (CCS), Adult Protective Services (APS), and hospital case managers.
- **Internal referrals:** Any CenCal Health staff member may identify and refer potential quality issues through internal processes.

A PQI may be reported to the Quality Department by submitting a completed PQI Referral Form to PQI@cencalhealth.org.

Review Process

- PQIs with a clinical component are reviewed by CenCal Health's Clinical Quality team.
- The review includes an evaluation of relevant medical records and a request for a written response from the provider regarding the identified concern. When appropriate, the review may also involve consultation with the provider. Before a final determination is made, providers have the opportunity to submit any relevant information for consideration.
- Additional information, including a focused site review, may be requested to support the investigation.
- Clinical findings are evaluated by the Chief Medical Officer (CMO) or physician designee to determine whether care met accepted standards of practice.
- When opportunities for improvement are identified, CenCal Health may provide feedback, education, compliance actions, or other quality improvement interventions. Depending on the nature and severity of the concern, CenCal Health may require a formal Notice to Improve or Corrective Action Plan (CAP) to address identified deficiencies and support compliance with applicable standards of care and performance expectations.
- Cases requiring additional review may be referred to the Peer Review and Credentialing Committee (PRCC). Findings may also be considered during credentialing, recredentialing, or other provider oversight activities, as applicable.
- Ongoing monitoring of providers may be required to ensure that clinical practices continue to meet standards of care.
- All PQI investigations, peer review activities, and related documentation are maintained in a confidential manner and are disclosed only as permitted or required by applicable laws, regulations, and accreditation standards.

Provider Responsibilities

Providers are contractually required to cooperate with CenCal Health's PQI review and QOC investigation processes. This includes but is not limited to:

- Timely submission of requested medical records, written responses, and other relevant documentation within the timeframe specified by CenCal Health.
- Participation in provider consultation or discussion when requested to support review of the identified concern.
- Cooperation with any on-site review conducted as part of a PQI review or
- investigation, including providing access to requested records, policies and procedures, and other information relevant to the review.
- Implementation of required compliance actions, Notice to Improve, CAP, improvement activities, or monitoring requirements, as applicable.
- Maintenance of confidentiality of PQI investigations, peer review activities, and related documentation in accordance with applicable laws and regulations.

Failure to cooperate may result in additional oversight action, including referral to the PRCC, consideration during credentialing or recredentialing, and/or other actions available under CenCal Health's provider agreements, policies, and applicable requirements.

Member Rights

When a PQI investigation is initiated as a result of a member complaint or grievance, CenCal Health will notify the member of the outcome of the investigation in accordance with applicable requirements.

If the resolution includes an adverse decision affecting the member, CenCal Health will provide notice of any applicable appeal rights and instructions for filing an appeal. Please refer to **Section O2: Member Grievance and Appeal Process** for additional information.

CenCal Health maintains member-facing grievance, appeal, and QOC materials in English and Spanish, its threshold languages. Interpreter services and bilingual assistance are available at no cost to members to facilitate communication throughout the grievance, appeal, and PQI processes. Please refer to **Section N: Language Assistance Program** for more information.

References:

DHCS Medi-Cal Managed Care Agreement

DHCS All Plan Letter 24-004

DHCS All Plan Letter 21-011

42 C.F.R. § 438.340 Managed Care State Quality Strategy

42 C.F.R. § 438.330 Quality Assessment and Performance Improvement Program

42 C.F.R. § 422.629(k)(2): Evidence Requirements for Integrated Grievances and Reconsiderations

Reference Link:

CenCal Health's QIHETP: www.cencalhealth.org/providers/quality-of-care/quality-program/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

L3: Medical Record Review Process & Requests (Quality Measures)

Medical Record Review Process

CenCal Health conducts reviews throughout the year in alignment with Healthcare Effectiveness Data and Information Set (HEDIS), CMS, and other applicable quality measurement requirements. These reviews include the following key steps:

- Defining the scope of the review, including the identification of members who meet the measure inclusion criteria based on continuous eligibility, age, gender, medications, or diagnoses, or other applicable requirements.
- Identification of members who have received clinically recommended services through claims or other data sources.
- Incorporating supplemental data sources, as applicable, including information from the California Immunization Registry (CAIR), the California Department of Health Care Services (DHCS), the California Department of Public Health, and a subset of CenCal Health's largest laboratory partners.
- Conducting medical record reviews when evidence of the clinically recommended services is not available through claims or supplemental data sources, and when supplemental medical record data collection is permitted. This process is completed in the least intrusive manner possible.
- Once all records have been obtained, staff will document the results of findings based on review against established criteria.
- Reporting of quality-of-care findings for all CenCal Health lines of business is conducted annually and submitted to relevant governing and accreditation agencies in alignment with their respective timelines.

Responding to Medical Record Requests

CenCal Health requires timely and complete responses to medical record requests from our Provider Network to meet federal and state requirements. Provider collaboration is essential to CenCal Health's mission to deliver high-quality, coordinated care to our members.

Provider Obligations

- Providers are contractually obligated to grant CenCal Health or its representatives access to medical records without any fees.
- Providers must have procedures in place that allow for timely access and prompt submission of these records upon request. Prompt submission of records

guarantees accurate reporting and safeguards against compliance risks, missed deadlines, and potential penalties.
- Records must be provided even if the member is no longer assigned to your practice, has transferred care, or is deceased, when the request pertains to dates of service during the member's enrollment with CenCal Health.

Requests and Submission Process

CenCal Health is dedicated to ensuring a smooth and efficient process for requesting medical records during audits and enhancing communication within our provider network. Staff will coordinate medical record collection through one or more of the following methods, most appropriate for the provider practice:

- Secure remote EMR access.
- Secure fax request.
- Electronic upload to a secure portal.
- On-site medical record review or scheduled pick-up.

Providers are encouraged to use the submission method that best aligns with their operational workflow and supports timely, efficient delivery of records to CenCal Health.

Documentation Requirements and Deadlines

All requests will include a "pull list" with the names of members and dates of service requested. The original pull list must be returned with the records, including any notes indicating:

- If the member has not been seen in your practice.
- If the record is unavailable, and the reason why.

Documentation is required even for members who are no longer associated with the provider's office or who are deceased, as data may pertain to services rendered while they were members of CenCal Health.

Each request will include a **specific due date**. Records submitted after CenCal Health's final data submission to state or federal agencies cannot be accepted for reporting purposes. Providers are encouraged to submit records as early as possible to allow for prompt processing and follow-up if needed.

Remote Electronic Medical Record (EMR) System Access

CenCal Health's preferred method for medical record review is secure, remote access to provider electronic medical record (EMR) systems. This allows for accurate, efficient, and comprehensive review of patient care, including clinical details that may not be captured through claims data alone. When remote access is not available, CenCal Health will accept other data sources, such as EMR data submissions, that can help reduce provider burden.

For questions about submitting medical record documentation, please contact CenCal Health's Quality Measurement team at 805-562-1609 or QMGRP@cencalhealth.org.

HIPAA
All providers are contractually obligated to provide CenCal Health with medical records upon request without requiring a patient release form. HEDIS data collection and related disclosures are permitted under HIPAA since the disclosure of records is part of quality assessment and improvement activities. CenCal Health maintains protected health information in accordance with applicable federal and state privacy requirements and regulations, whether records are accessed through provider EHR systems or submitted through an alternative approved method.

Source: www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

L4: Quality Care Incentive Program

The Quality Care Incentive Program (QCIP) supports Primary Care Providers (PCPs) in delivering comprehensive, high-quality services. The program promotes the use of evidence-based treatment, screenings, and preventive health services to strengthen care delivery, improve quality performance, promote a positive member experience, and support better health outcomes for CenCal Health members.

Quality Measures
Quality measures include aspects of care that PCPs can influence through direct care, referral to specialists, or coordination with ancillary practitioners. Identified incentivized measures are consistent with accepted clinical guidelines and are clinically relevant to CenCal Health's membership.

Quality measures are organized into the following domains:

- **Clinical Measures:** Cancer Prevention, Managing Chronic Conditions, Behavioral Health, and Staying Healthy
- **Operational Measures:** Member Experience (member surveys)

QCIP quality measures may be found on the Quality Care Incentive Program webpage. Clinical measure specifications reflect applicable nationally recognized measure specifications, including National Committee for Quality Assurance (NCQA) HEDIS® Volume 2 Technical Specifications and Centers for Medicare & Medicaid Services (CMS) measure specifications, as applicable. Specifications are updated as measure requirements change. Generally, measures remain in the program for at least two years to reinforce improvement priorities and expectations, support program stability for PCPs, and increase the potential to achieve overall network performance that meets or exceeds external benchmarks of clinical excellence.

Measures
Measures are systematically identified for inclusion based on the following criteria:

- Clinical importance for CenCal Health's membership.
- Identified opportunities to improve quality performance for CenCal Health members.
- Feasibility of accurate quality of care measurement using claims, laboratory, registry, or other reliable data sources.
- A balanced distribution of adult and pediatric measures.
- A balanced distribution of disease management and preventive care measures.
- Alignment with statewide recommended quality focus areas.
- PCP-level accountability and direct influence over performance outcomes.
- Relevance to member health outcomes and member experience across applicable lines of business.

Quality measures may be designated as incentivized or non-incentivized to support a balanced and purposeful approach to performance improvement. Incentivized measures are eligible for performance-based payments, while non-incentivized measures are monitored and reported to help identify emerging opportunities for improvement. Over time, non-incentivized measures may be considered for future incentive alignment based on program criteria, quality priorities, clinical relevance, and strategic value.

Quality measures are reviewed annually to ensure the program remains aligned with established criteria, organizational priorities, and evolving quality improvement needs. As priorities evolve, CenCal Health may update measures no more than once annually, with PCPs receiving at least 12 months' advance notice before any changes are implemented.

Performance & Payment Methodology

Performance measurement methodology is applied equally to Medi-Cal capitated PCPs and all Medicare Dual Eligible Special Needs Plan (D-SNP) PCPs, including but not limited to Federally Qualified Health Centers and Rural Health Centers. Incentive payments are not paid as an additional rate per service or encounter. Performance is measured using pre-defined, industry-standard clinical and operational measures. Measurement results are calculated using NCQA-certified HEDIS® reporting software and Consumer Assessment of Healthcare Providers and Systems (CAHPS)-like survey methodology.

QCIP applies across applicable lines of business and products, including Medi-Cal and Medicare D-SNP populations. Funding is managed, monitored, and financially differentiated by line of business for CenCal Health's internal financial oversight. For performance management, PCP reporting is organized by domain and aspect of care, regardless of line of business, to promote a consistent standard of care across all applicable populations.

Performance Reporting

CenCal Health provides monthly gaps-in-care performance reporting to PCPs as a practical tool to support timely outreach, strengthen primary care delivery, and help

members receive recommended preventive, screening, and evidence-based services. These reports may be used strategically to identify performance trends, prioritize provider support, recognize member-level barriers, and guide targeted interventions that close care gaps and improve quality outcomes.

Performance reporting is updated monthly for all PCPs and is available in the QCIP module within the Provider Portal on CenCal Health's website, www.cencalhealth.org. Reporting consists of three sections:

- QCIP Dashboard
- QCIP Performance Overview
    - Clinical and Operational Measure Reporting
- QCIP Financial Overview

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

Payment

QCIP incentive payments are issued quarterly to eligible PCPs as a single incentive payment. The payment may include a clinical incentive component, an operational incentive component, or both, based on whether the PCP meets the applicable performance and minimum denominator criteria for each category. Payment performance is calculated, expressed, and reported for each incentivized measure and across all combined incentivized measures within the clinical and operational categories.

Clinical incentive performance recognizes PCP completion of preventive, screening, and other evidence-based services. Operational incentive performance recognizes members' experiences with their PCPs, as reflected in collected member survey responses.

- Individual PCP performance is calculated as a percentage using the applicable numerator divided by the applicable denominator for each qualifying measure. For clinical measures, the numerator includes members who received the service, and the denominator includes eligible members. For operational measures, the numerator includes positive member experience survey responses, and the denominator includes eligible member experience survey responses.
- A PCP's overall performance is calculated separately for clinical and operational measures. For each category, overall performance is based on the sum of all applicable measure numerators divided by the sum of all applicable measure denominators.
- Clinical and operational performance is expressed using a 5-star performance scale based on quintiles.
- Clinical and operational star ratings (quintiles) are assigned for each measure, and for all measures in aggregate, by:
    - Ranking PCPs in descending order by their aggregate performance percentage.
    - Stratifying the population by quintiles.
    - Assigning stars to each quintile, with 5 stars representing the top-

performing quintile and 1 star representing the first quintile performance range.

- If multiple PCPs have the same aggregate clinical score, PCPs with equal scores will be included in the higher quintile.
- PCPs earn incentives according to the number of stars earned:
    - Quintile 5 = 5 stars = 100% of total at-risk available funding
    - Quintile 4 = 4 stars = 80% of total at-risk available funding
    - Quintile 3 = 3 stars = 60% of total at-risk available funding
    - Quintile 2 = 2 stars = 40% of total at-risk available funding
    - Quintile 1 = 1 star = 20% of total at-risk available funding

- Incentive payments are issued quarterly. Clinical measure calculations generally reflect at least the prior 12 months of performance, although some measures may have a longer look-back period based on applicable clinical guidelines. Operational measure calculations reflect the prior three months of performance. Each payment calculation period rolls forward quarterly.
    - **Clinical:** PCPs with fewer than 30 members across <u>all</u> incentivized clinical measures combined do not qualify for a clinical incentive payment for that quarterly calculation period.
    - **Operational:** PCPs with fewer than 30 survey responses across <u>all</u> incentivized operational measures combined do not qualify for an operational incentive payment for that quarterly calculation period.
- In lieu of an earned QCIP incentive, PCPs receive payment equal to the capitation withhold that they did not have the opportunity to earn. This capitation withhold is applicable only to the Medi-Cal line of business.

Dashboard

The QCIP Dashboard provides a trended snapshot of each PCP's overall program performance and financial performance, with the ability to filter results by reporting timeframe. The dashboard helps CenCal Health and PCPs better understand performance trends, identify opportunities for support, align financial incentives with quality improvement priorities, and guide targeted interventions that close care gaps and support better outcomes for members.

Performance Overview: Clinical and Operational

The QCIP Performance Overview displays each PCP's quality scoring and trended performance across clinical and operational measures. It includes:

- The PCP's trended performance, which can be filtered by:
    - PCP location
    - CenCal Health identified quality measures for improvement
    - Incentivized quality measures (incentivized measures have a dollar sign, $)
    - Population served
    - Time frame
- The PCP's quality performance score by month is reflected on the trend line, and performance rates can be displayed by hovering over the trend line marker.

- Each trend line marker can be selected to display the corresponding month's performance details on the QCIP Provider Summary Detail screen. Clinical performance reporting supports drill-down functionality to the member-detail level. Member-level drill-down is not available for operational measures because survey responses are anonymous. The detail screen includes:
    - Number of members in each measure domain.
    - Number of members who met the criteria for all measures.
        - Select the number in this field to drill into member details.
    - Number of members in each measure category who have not met the criteria for all measures.
        - Select the number in this field to drill into member details.
    - Overall measure domain rate.
    - Number of members in each measure.
    - Number of members who met the criteria for a specific measure.
        - Select the number in this field to drill into member details.
    - Number of members who have not met the criteria for a specific measure.
        - Select the number in this field to drill into member details.
    - Specific measure rate.
    - Number of overall eligible members in the program who met the criteria.
        - Select the number in this field to drill into member details.
    - Overall program rate compared to the average overall CenCal Health rate.
- For clinical measures, all member details include: PCP name, member ID number, member name, member date of birth, member age, member gender, member phone number, member address, member city, member state, member zip code, measure domain, and measure name.
    - Select the member's ID number to view the Member 360 screen.

Financial Overview

The QCIP Financial Overview displays each PCP's trended incentive payments and available incentive funding. It includes:

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

- QCIP Payment Scoring Detail includes:
  - Incentive Date
  - Provider NPI
    - Select on the number in this field to drill into the payment detail, which includes:
      - Incentive date
      - Provider NPI
      - Total Incentive Payment
      - Member ID
      - Member Name
      - Member Date of Birth
      - Measure Name
      - If the member triggered an incentive payment
  - Provider Name
  - Clinical Performance Percentage
  - Clinical Stars Earned
  - Clinical Funding Available
  - Clinical Percentage of Funding Earned
  - Clinical Payment Earned
  - Operational Performance Percentage
  - Operational Stars Earned
  - Operational Funding Available
  - Operational Percentage of Funding Earned
  - Operational Payment Earned
  - Medi-Cal Capitation Withhold
  - CenCal Contribution
  - Total Funding Available

Provider Ranking

The Quality Care Incentive Program Monthly Provider Ranking Report displays providers' star rankings in descending order by their performance score. Two provider ranking reports are available: one for clinical performance and one for operational performance among qualified providers. Ranking reports can be filtered by time frame.

QCIP monthly Provider Ranking Reports include:

- Provider Name
- Star Ranking
- Performance percentage (%) score
- Earning percentage (%)

Program Support
CenCal Health's QCIP Team, Practice Transformation, and Provider Relations Departments support PCPs by providing orientation on quality measures, strategies to maximize data reporting, and best practices to support evidence-based treatment, preventive health guidelines, and appropriate service utilization. Contact CenCal Health using the contact information below for additional support:

- **QCIP Team Email:** qcip@cencalhealth.org
- **Practice Transformation:** practicetransformation@cencalhealth.org
- **Provider Relations Email:** psrgroup@cencalhealth.org or your assigned Provider Relations Representative

More information can also be found here:
www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

https://www.cencalhealth.org/providers/provider-portal/www.cencalhealth.org/providers/provider-training-resources/

For assistance accessing resources in the Provider Portal or for additional Provider Portal training, please contact CenCal Health's Webmaster via email at webmaster@cencalhealth.org.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

L5: Performance Monitoring and Reporting

CenCal Health uses performance monitoring as a tool to assess care delivery, identify improvement opportunities, and achieve meaningful outcomes for members. In alignment with priorities established by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS), standardized quality measurement and reporting guides accountability, informs quality improvement priorities, and supports sustained performance across CenCal Health's Medicaid and Medicare populations. Through this structured approach, CenCal Health strengthens informed decision-making and advances measurable improvements in quality and equity, along with member experience, care, and health outcomes.

Healthcare Effectiveness Data & Information Set (HEDIS)
The Healthcare Effectiveness Data & Information Set (HEDIS[1]) is the primary tool used by CenCal Health to measure the quality of health care provided to our members. Developed by the National Committee for Quality Assurance (NCQA), HEDIS provides a standardized methodology that is used nationally by health plans and regulators to evaluate important aspects of care.

CenCal Health's recognition as a leading managed care organization in California is reflective of the high-quality care delivered by its provider network, the organization's sustained performance across key quality measures, and the excellent healthcare afforded to its members.

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey is a standardized member experience survey used by NCQA within the HEDIS Experience Care Domain and by the CMS for quality measurement oversight and program accountability across Medicaid, Medicare, and other CME-administered programs. The CAHPS survey methodology is a standardized approach for collecting member-reported experience data using approved sampling, survey administration, response rate, and reporting protocols. This methodology supports reliable comparison across health plans, informs quality improvement priorities, and ensures results are reported in alignment with NCQA, HEDIS, and CMS requirements.

CAHPS collects member-reported information on access, timeliness of care, provider communication, customer service, care coordination, and overall ratings. Results provide an auditable view of health plan performance and help identify opportunities to improve member experience, access, communication, and care coordination. Key CAHPS survey components include:

- Access and Timeliness of Care: Member experience obtaining needed care and services within appropriate timeframes.
- Provider Communication: How well providers explain information, listen, show respect, and spend sufficient time with members.
- Care Coordination: How effectively care and services are organized across providers, settings, and the health plan.
- Customer Service and Health Plan Support: Member experience with plan responsiveness, issue resolution, and navigation support.
- Overall Ratings: Member ratings of the health plan, care received, personal doctor, and specialists, as applicable.

Medi-Cal Managed Care Accountability Set (MCAS)
The Department of Health Care Services (DHCS) annually establishes the Medi-Cal Managed Care Accountability Set (MCAS), a defined set of performance measures that all Medi-Cal managed care plans are required to report on to support statewide accountability, quality oversight, and performance improvement priorities.

The MCAS list for Measurement Year (MY) 2026/Reporting Year (RY) 2027 consists of 29 performance measures. These can be accessed here: Performance Measures | CenCal Health Insurance Santa Barbara and San Luis Obispo Counties

For Measurement Year (MY) 2026/Reporting Year (RY) 2027, 20 MCAS measures are subject to a DHCS-established Minimum Performance Level (MPL), using the NCQA Medicaid 50th percentile as the performance benchmark. CenCal Health is expected

to meet or exceed each applicable DHCS MPL. Performance below the established threshold may require DHCS-directed quality improvement activities, formal corrective action planning, enhanced monitoring, and/or financial sanctions, depending on the measure, degree of underperformance, and applicable DHCS requirements.

NCQA Accreditation – Health Plan Ratings Measures

As an NCQA-accredited health plan, CenCal Health is evaluated based on established standards, demonstrating its unwavering commitment to delivering quality care and enhancing member outcomes. CenCal Health is reviewed annually for operational performance, including access to care and patient satisfaction. The annual NCQA Accreditation audit ensures compliance with these standards. It assesses care quality through performance measures, documentation accuracy, and regulatory adherence, enabling the identification of opportunities for improvement. This process supports CenCal Health's ongoing commitment to strengthening quality performance, advancing member health outcomes, and maintaining alignment with NCQA accreditation standards.

NCQA compiles an annual list of performance measures called NCQA Accreditation - Health Plan Ratings measures and requires all accredited health plans to report on these priorities. The required measure listing for Measurement Year (MY) 2026/Reporting Year (RY) 2027 consists of 37 performance measures. These can be accessed here: www.ncqa.org/hedis/health-plan-ratings/

CMS Star Measures (CenCal CareConnect only)

The Centers for Medicare and Medicaid Services (CMS) partners with Medicare Advantage Plans, such as CenCal CareConnect (HMO D-SNP), to enhance the quality, performance, and cost-effectiveness of services offered to Medicare beneficiaries. The Medicare Stars program assesses the performance of CenCal Health, and its provider network based on a variety of quality measures, which include member satisfaction (from both plans and providers, CAHPS survey), health outcomes (Health Outcomes Survey or HOS), and operational efficiency. CenCal Health is rated based on its ability to provide high-quality care, improve beneficiary protections, and enhance accountability among providers. These ratings are publicly reported annually. It uses a five-star scale, with a five-star rating representing excellence. The star ratings are determined using the following categories:

- Staying Healthy (Screenings, Tests, and Vaccines)
- Management of Chronic Conditions (Long-Term)
- Member Experience with Health Plan (Getting Appointments and Care Quickly, Customer Service, Care Coordination, Health Plan Rating)
- Access and Experience (Customer Experience, Member Experience with Health Plan, Access to Care)
- Administrative Performance and Compliance Standards (Grievance, Appeals, Complaint tracking)
- Health and Drug Plan Quality Improvement

These measures can be accessed here: www.cms.gov/files/document/2027-star-ratings-measures.pdf

Data Collection Methodologies:
CenCal Health's Performance Measures discussed above are collected through several data collection methods. Below is a brief description of those data collection methodologies.

- **Administrative:** Measure compliance via Claims, Pharmacy, Immunization Registry, and Supplemental Data.
- **Hybrid:** Measure compliance via Administrative, plus medical record review.
- **Electronic Clinical Data Systems (ECDS):** Measure compliance via Administrative, plus data from an Electronic Medical Record, Health Information Exchange (HIE)/Clinical Registry, and Case Management System.
- **Survey:** Conducted via phone or mail, this is a standardized data collection method used to gather information directly from a defined population through a structured set of questions.

Strategic Quality Monitoring Framework:
CenCal Health's performance monitoring framework is anchored in HEDIS as the foundational audit and measurement structure, with related measure sets and specifications reflected in MCAS, NCQA Health Plan Ratings, and CMS Stars, along with the CAHPS member experience survey. Together, these tools provide a comprehensive view of quality, access, member experience, regulatory accountability, provider network performance, and health plan outcomes. By bringing these insights together, CenCal Health can better understand where members and providers may need additional support, strengthen organizational strategy, and guide targeted interventions that close care gaps and advance improvements in members' health, care, and experience.

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

Reference Links:

Complete list of CenCal Health Quality measures, including Medi-Cal Managed Care Accountability Set:
www.cencalhealth.org/providers/quality-of-care/performance-measures/

NCQA Accreditation - Health Plan Ratings measures: www.ncqa.org/hedis/health-plan-ratings/

Medicare STARS:
www.cms.gov/files/document/2027-star-ratings-measures.pdf

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

L6: Quality Improvement Activities

As part of the Quality Improvement and Health Equity Transformation Program (QIHETP), CenCal Health implements a variety of quality improvement activities to drive meaningful improvements in care delivery and health equity for its members. These activities comply with the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements to monitor, evaluate, and improve identified performance and health outcome disparities (refer to Section L1: Quality Improvement System).

Providers are essential to the success of member-focused activities such as Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs).

Contracted providers are expected to collaborate with and support CenCal Health's quality improvement initiatives, including but not limited to:

- PIPs/QIPs.
- Utilization and care management programs.
- Quality improvement efforts targeting gaps identified through MCAS, CAHPS, Health Outcomes Surveys (HOS), HEDIS, or other data sources.
- Initiatives focused on identifying and reducing health disparities and advancing equity.
- Process or policy enhancements designed to improve member experience, access to care, and clinical and operational performance.

These activities support CenCal Health's overarching goal of ensuring high-quality, equitable, and person-centered care for all members. They focus on, but are not limited to, preventive care, cancer screenings, chronic disease management, behavioral health, maternal health, and care management.

CenCal Health collaborates with providers whose data and service populations align with prioritized improvement efforts and may request participation to support specific PIP/QIP goals.

Communication and Transparency
CenCal Health communicates quality-related findings and performance through multiple channels:

<u>Providers</u>

- CenCal Health website and Provider Portal.
- Monthly provider bulletins and e-blasts.
- Site visit reports.
- Medical Record Review findings and feedback.
- Quality committee meetings (e.g., QIHEC).

Members

- CenCal Health website and Member Portal.
- Member newsletters and other member communications.
- Educational materials and outreach campaigns.
- Health promotion and preventive health reminders, as applicable.

This multi-channel approach supports awareness of CenCal Health's quality performance to promote continuous quality improvement and encourage provider and member engagement to improve health outcomes and advance health equity. Public performance results and quality improvement information can be accessed at: www.cencalhealth.org/providers/quality-of-care/

Reference Links:

42 CFR 438.330 -- Quality assessment and performance improvement program
www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.330

42 CFR 422.152 -- Quality improvement program
www.ecfr.gov/current/title-42/section-422.152

Medi-Cal Managed Care Contract, Exhibit A, Attachment III, Section 2.2.

DHCS All-Plan Letter 24-004 Quality Improvement and Health Equity Transformation Requirements
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2024/APL24-004.pdf

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

L7: Social Drivers of Health (SDOH)

Social Drivers of Health (SDOH), also referred to as Social Determinants of Health or Health Related Social Needs, are the environment(s) in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Consistent and reliable collection of SDOH data is vital to identifying ways to support our members.

There are several health-related social factors that can be improved through the analysis of members' characteristics, health, social, and risk needs. Our providers are

the key to identifying these health disparities and their root causes, which negatively impact our members' health.

Coding for SDOH

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

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

Please reference CenCal Health's Social Drivers of Health website resource page for the full list. The list is subject to DHCS revisions and additions to improve alignment with SDOH data elements.

Reference Links:

DHCS APL 21-009
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf

Social Drivers of Health
www.cencalhealth.org/providers/social-drivers-of-health-sdoh/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

L8: Basic Population Health Management

CenCal Health maintains a Basic Population Health Management (BPHM) program in accordance with the Department of Health Care Services (DHCS) Population Health Management requirements. The BPHM program is designed to promote prevention, wellness, early identification of health risks, care gap closure, care coordination, and the integration of physical, behavioral, and social services. BPHM is an approach to care that ensures the programs and services needed are made available to each member, regardless of the member's risk and Social Drivers of Health (SDOH), at the

right time, in the right setting, and in a culturally and linguistically competent manner that are responsive to member needs, beliefs, and preferences.

Participating providers play a critical role in supporting CenCal Health's BPHM Program and shall cooperate with the population health activities by:

1. **Providing preventive and wellness services** consistent with applicable clinical practice guidelines and DHCS requirements.
2. **Conducting health screenings, assessments, and evaluations** necessary to identify medical, behavioral health, oral health, and social needs that may affect a member's health outcomes.
3. **Identifying and addressing gaps in care** and assisting members in obtaining recommended preventive services, screenings, immunizations, and follow-up care.
4. **Documenting and communicating relevant clinical information** to support CenCal Health's population health, risk stratification, care management, and quality improvement activities.
5. **Coordinating care across providers, settings, and delivery systems** to support continuity of care and improve member health outcomes.
6. **Screening for social drivers of health (SDOH)** and referring members to appropriate community resources, social services, care management programs, or other available supports when needs are identified. Section L9: Social Drivers of Health contains more information about SDOH diagnosis codes (Z Codes).
7. **Cooperating with CenCal Health's care management, Enhanced Care Management (ECM), Complex Care Management (CCM), and Transitional Care Services (TCS) activities**, as applicable to the member's needs.
8. **Responding to MCP outreach and requests for clinical information** to facilitate care coordination, risk assessment, quality improvement, and population health initiatives.

Provider Resources

CenCal Health provides the following resources to support providers with care management referrals:

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

- Other training and provider supports for working with CenCal Health, as further described in Section B3: Provider Education and Training Resources of this Manual.

References:

Medi-Cal Managed Care Contract, Exhibit A
www.dhcs.ca.gov/wp-content/uploads/2025/10/2024-Managed-Care-Boilerplate-Contract.pdf

CalAIM Population Health Management Policy Guide
www.dhcs.ca.gov/wp-content/uploads/2025/10/PHM-Policy-Guide.pdf

American Academy of Pediatrics (AAP) Bright Futures
www.aap.org/en/practice-management/bright-futures

United States Preventive Services Taskforce
www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

Section M: Member Services

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

M1: Member Rights and Responsibilities

In accordance with the applicable requirements outlined in Section D9: Compliance with Statutes and Regulations:

CenCal Health does not prohibit or restrict a health care professional acting within their lawful scope of practice from advising or advocating on behalf of a member about:

- The member's health status, medical care, treatment options, or alternative treatment options (including any alternative treatment that may be self-administered), including obtaining any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment; or
- The member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

CenCal Health does not contract for physicians, health care professionals, or providers to indemnify the plan against any civil liability for damage caused to a member as a result of the plan's denial of medically necessary care.

CenCal Health will not take punitive action against a provider who either requests an expedited resolution or supports a member's appeal.

The CenCal Health Medi-Cal Member Handbook and our CenCal CareConnect Member Handbook will explain those rights and responsibilities. Please visit the CenCal Health website to view or download a copy.

You may also access the Member Rights & Responsibilities via a dedicated menu option on CenCal Health's website.

Reference Links:

CenCal Health (Medi-Cal) Member Handbook
www.cencalhealth.org/members/member-handbook/

CenCal CareConnect Member Handbook
www.cencalhealth.org/careconnect/cencal-careconnect-materials/

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

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

M2: Nondiscrimination Notice

Discrimination is against the law. CenCal Health follows state and federal civil rights laws. CenCal Health does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group, identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. To learn more about Notice of Non-Discrimination, please visit the CenCal Health website and download the CenCal Health Medi-Cal Member Handbook or the CenCal CareConnect (HMO D-SNP) Member Handbook.

Reference Links:

CenCal Health Medi-Cal Member Handbook
www.cencalhealth.org/members/member-handbook/

CenCal CareConnect Member Handbook
www.cencalhealth.org/careconnect/cencal-careconnect-materials/

This section applies to the following CenCal Health programs:

Medi-Cal

M3: Mid-Month Process

Mid-Month changes are made to facilitate continuity of care and prevent access problems. Requests for Mid-Months can be made by either the member or the provider. If a provider calls CenCal Health to request a Mid-Month change, CenCal Health needs to speak with the member before the request can be approved.

Please note: Mid-month selections will not apply to CenCal CareConnect members; CenCal CareConnect member PCP changes will be on a month-to-month basis (effective 1st of the following month).

The following are the guidelines regarding Mid-Months:

- The cut-off date (last date) to request a Mid-Month will vary from month to month, but is usually around the 13th or 14th of the month. After this date, we will no longer be able to change a member's PCP retroactively to the 1st of the current month.
- **All Mid-Month changes are retroactive to the first of the current month,** regardless of the day on which the Mid-Month was processed and/or approved. By

approving Mid-Month, the provider agrees to case manage a member for all medical care received retroactively to the first day of the month.
- CenCal Health's eligibility system and website eligibility system will be updated immediately to reflect Mid-Month changes. Providers are urged to make notations to their monthly capitation report, indicating a Mid-Month addition to their list as well as a Mid-Month removal. **Please remember that a provider can treat a member immediately after the Mid-Month has been approved.**
- A Mid-Month Capitation Report is generated after the cut-off date and mailed to the provider. It will list all members that were retroactively added back to the first of the current month.

The Member Services staff uses the following Mid-Month criteria:
- The member has an established relationship with the PCP they are requesting
- The member has an appointment in the current month
- The member needs ongoing or urgent care.
- The member needs a Child Health and Disability Prevention (CHDP) Program exam and/or immunizations
- The member has not been seen in the current month by the PCP to whom they are currently assigned

If, for whatever reason, a Mid-Month does not process correctly, CenCal Health has an administrative referral process by which a provider's claim can be processed. Therefore, if the provider approves the Mid-Month and determines that the member does not appear on their capitation report, the provider can request an administrative referral from CenCal Health, which will ensure that the provider's claim is processed and will not require a referral from the original PCP.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

M4: Assistance with Member No-Shows

CenCal Health recognizes that members missing their appointments can create scheduling issues for providers. CenCal Health's Member Services Department offers support and assistance with member "no-shows" through member coaching and education, important tools when helping members understand the importance of keeping scheduled appointments and the consequences should they miss them.

Providers can request the following assistance by contacting the Member Services Department:
- Member Services contacts the member and provides "*direct one-on-one*" education regarding missed appointments. This should occur as soon as the provider identifies that the member has missed an appointment without canceling, thereby addressing the issue before it becomes a problem.

- If transportation has been identified as a barrier to keeping appointments, Member Services can provide members with information regarding alternate transportation and offer referrals to community resources.
- Member Services will strive to identify and address any other issues that may be causing the member to miss appointments.

Articles regarding the importance of keeping scheduled appointments regularly appear in the CenCal Health Member Newsletter.

Providers can call the Member Services Department for assistance at 1-877-814-1861 or fax a list of members with the members' CenCal Health ID number and the dates of the missed appointments to the Member Services fax number at 1-805-692-1684. Providers will be notified once education has been provided.

Section N: Language Assistance Program

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

N1: Obtaining Access to Cultural and Linguistic Services

State and federal regulations require CenCal Health to make interpreter and translation services available to Limited English Proficient (LEP) members. LEP members include those who have a limited ability to read, speak, write, or understand English. CenCal Health is also required to facilitate, promote, and provide training in cultural competency for its staff, as well as for health network staff and CenCal Health providers. CenCal Health's Cultural and Linguistic Services program provides and facilitates qualified interpreter and translation services, free of charge to members and providers.

Members are not expected to bring their own interpreters. Children, family members, and other untrained adults should not be used to interpret during medical encounters.

The Department of Health Care Services (DHCS) periodically audits CenCal Health's Language Assistance Program, which includes interpreter and translation services, as well as our provider trainings. DHCS auditors may select individual provider offices to review as a part of this audit, to verify whether LEP members are informed of the availability of language assistance and have been offered free, qualified medical interpreter services. CenCal Health will contact provider offices selected by the DHCS in advance to participate in its cultural and linguistic services audit when possible.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

N2: Accessing Interpreter Services

Providers may request interpreter services for their CenCal Health patients with Limited English Proficiency (LEP). We encourage providers to use CenCal Health's 24/7 telephonic/over-the-phone interpreting (OPI) services for most routine appointments. Video Remote Interpreting (VRI) for ASL, Spanish, and 19 other languages is also now available for specialty appointments through Certified Language International (CLI) by using their assigned Access Code. Providers may also request face-to-face interpreter services (Spanish, Mixteco, ASL) if the criteria for these services are met for a network interpreter to be sent to the appointment, when available. Providers needing a Mixteco interpreter can pre-schedule these services through Certified Language International (CLI) or, if CLI is unable to fulfill the request directly, through CenCal Health Member

Services. For help in identifying your patient's preferred language, see the Provider section of the CenCal Health website.

How to Request Interpreter Services

- Verify the member's eligibility and identify if the member is enrolled with CenCal Health. The member MUST be a member of CenCal Health to use CenCal Health interpreting services, and you may be responsible for payment if determined to be misusing services for non-CenCal Health members.

    - **Telephonic/over-the-phone interpreter service (OPI)** is to be used for all routine services that do not meet the criteria as noted in Section N7: Language Access Program. This service is available 24 hours a day, seven days a week.

    - **Video Remote Interpreting (VRI) service** is to be used for ASL members and 21 other spoken languages available on demand. Please note that only ASL and Spanish are available 24/7 without the need to schedule ahead of time (on demand). For cost-effectiveness, CenCal Health asks providers to utilize CLI's telephonic/OPI interpreting services whenever possible and to use VRI for complex appointments, for American Sign Language, or when telephonic interpretation is not an effective means of communicating with a particular member. For a list of all languages, go to www.cencalhealth.org/providers/cultural-linguistic-resources/.

    - **Face-to-face (in-person) Spanish, Mixteco, and ASL interpreter services** are available based upon the noted criteria in Section N7. This service is available for scheduled medical appointments in an ambulatory setting and requires the provider to call in the request with at least five working days' advance notice. **However, providers are encouraged to make the request as early as possible to increase the likelihood of an interpreter being available at the appointment time.**

    - **American Sign Language** is available on demand through VRI; however, if a face-to-face interpreter is needed to provide effective communication, please request at least five working days in advance**. Making the request as early as possible will increase the likelihood of an interpreter being available at the appointment time.**

    - **Mixteco interpreters** are available through CLI, but it is necessary that they be **requested prior to the appointment time** and preferably at least two weeks before. If CLI is unable to fulfill the request, the provider may request these services directly from CenCal Health. CenCal Health will ask for confirmation that CLI was unable to fulfill the request prior to scheduling a Mixteco interpreter directly.

- Please have the following information ready for face-to-face scheduling at the time of the request:
    - Member's name

- Member's CIN or ID#
- Member's gender and age
- Date and time of appointment
- Type of visit and approximate duration within the noted criteria (does not apply to ASL)
- Name of doctor/facility
- Address and phone number of appointment/location
- For Mixteco members only: Name of the town/pueblo they are from, to ensure a proper language match

- If the member is eligible with CenCal Health, please contact CenCal Health's Member Services Department by calling **877-814-1861** with any questions about accessing or scheduling interpreter services.

Reference Link:

Language List and Hours of Operation
www.cencalhealth.org/providers/cultural-linguistic-resources/

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

N3: Documenting Member Refusal of Professional Interpreter Services

CenCal Health ensures that qualified interpreters are professionally trained, culturally competent, adhere to interpreter ethical principles, and are well-versed in medical terminology and managed care concepts. Because of these requirements, it is important that providers' offices document when members refuse to use the free telephonic, video, or face-to-face qualified interpreter services provided by CenCal Health. We recommend documenting that free, qualified medical interpreter services were offered to the member in their preferred language, as well as documenting the refusal of any of the interpreter services available to providers (telephonic, VRI, or face-to-face) in the member's record. Documenting refusals can protect the provider and the provider's practice, and it ensures consistency when medical records are monitored through site reviews or audits to ensure the adequacy of CenCal Health's Language Assistance program.

Under Section 1557 of the ACA, an accompanying adult can provide interpretation in non-emergency situations if three conditions are met:

1. A member specifically asks that an accompanying adult be the interpreter.
2. That accompanying adult agrees to interpret.
3. Reliance on that adult for such assistance is appropriate under the circumstances.

Because providers still maintain the legal responsibility for providing qualified medical interpreters, **it is recommended that the provider document details for each encounter, including how all three conditions were met.**

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

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

CenCal Health recommends documenting in the member's medical record:

1. Whether the interpreter services were telephonic (OPI), VRI, or face-to-face.
2. Interpreter language, including ASL.
3. The name of the vendor providing services, i.e., CLI or CenCal Health.
4. Interpreter name and/or number.

If the member was offered interpreter services and they refused, **it is important to note in the member's record for that visit that free, qualified medical interpreter services were offered in the member's preferred language and were refused**.

Using a family member or friend to interpret should be discouraged. However, if the member insists on using a family member or friend, it is extremely important to document this in the medical record. Minors should never be used to interpret. Consider offering a telephonic or video interpreter in addition to the family member/friend to ensure accuracy of interpretation when this occurs. Please see Section N3 for details about information that should be documented when using a family member or friend to interpret.

For all Limited English Proficient (LEP) members, it is a best practice to document the member's preferred language in paper and or electronic medical records in the manner that best fits your practice.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

N5: Working with Interpreters for Face-to-Face, Telephonic, and Video Services

Certified Languages International (CLI - https://certifiedlanguages.com) hires the very best interpreters available. CLI ensures the competence of all its interpreters (telephonic and video). CLI's network of interpreters is qualified, experienced, trained, and required to pass a rigorous CLI interpreting credentialing process, including an assessment for language competency, cultural understanding, and interpreting skills, such as accuracy. For languages of lesser diffusion where no in-language assessments are available, qualification is assessed through a questionnaire.

Mixteco Indigena Community Organizing Project (MICOP) provides trained, qualified, and professional telephonic, video, and face-to-face Mixteco interpreters who follow established ethical principles when interpreting.

Face-to-face interpreters for Spanish and ASL are independent contractors who have been assessed and tested by national certifying bodies to assure the highest level of accuracy and professionalism.

However, language interpretation is a three-way conversation between yourself, your patient, and the interpreter. Please discuss concerns or issues together to improve all parties' experience and report any feedback you would like CenCal Health to know. Send feedback to CenCal Health's Cultural & Linguistic Services Manager, Denise Filotas, at dfilotas@cencalhealth.org.

Follow best practices when working with a qualified professional interpreter:

- Share basic information about the session with the interpreter prior to starting.
- Remember, the interpreter is obligated to interpret everything that is said by the patient and the provider, so do not say anything that you would not like to be interpreted.
- Speak and look directly at the patient. Avoid saying things like: "Please ask the patient how they are feeling today." Instead say: "How are you feeling today?"
- Speak in a normal tone, volume, and speed. Pause regularly to allow the interpreter time to interpret.
- Avoid complicated medical jargon, idiomatic expressions, or jokes, as they are difficult to interpret and may be culturally specific.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

N6: Working with Limited English Proficient (LEP) Members

It is important that providers know how to identify, offer, and access interpreter services for LEP members. Below are some recommended tips on how to work with members who are Limited English Proficient (LEP).

Who are considered LEP members? Individuals who do not identify English as their preferred language and who have a limited ability to read, speak, write, or understand English may be considered LEP. Members should be allowed to identify themselves as LEP and request an interpreter, even when you think that you are able to communicate effectively in English. The member's language preference should be given primary consideration.

How to identify LEP members over the phone. An LEP member may exhibit the following characteristics:

a) Is quiet or does not respond to questions.
b) Responds with a simple "yes" or "no," or gives inappropriate or inconsistent answers to your questions.
c) May have trouble communicating in English, or you may have a very difficult time understanding what they are trying to communicate.
d) Speaks in a manner that is hesitant, does not flow naturally, or does not use correct verb tenses.
e) Identifies as LEP by requesting language assistance.

How to offer interpreter services to a LEP member when a member does not speak English, and you are unable to discern the language. If you are unable to identify the language spoken by the LEP member, you should request telephonic or video interpreter services through Certified Languages International (CLI) to identify the language needed. You can also show members the CLI Language Identification card and have them point to the language that they speak.

How to best communicate with an LEP member who speaks some English but with whom you are having difficulty communicating. Speak slowly and clearly with the member. Do not speak loudly or shout. Use simple words and short sentences. Using a qualified interpreter is always recommended to ensure effective communication and to allow the member to fully understand and express themselves. If you are having trouble understanding the patient or are concerned they are not understanding you fully, you can always connect with an interpreter to assist you, even if the patient feels they do not need an interpreter.

How to offer interpreter services to the member. Here are a couple of recommended ways to offer interpreter services:

a) "I think I am having trouble explaining this to you, and I really want to make sure you understand. Would you mind if we connect with an interpreter to help us? Which language do you prefer to speak?"
b) "I am going to connect us with an interpreter. Which language do you speak at home?"
    i. Call Certified Languages International for assistance.

ii. If using Video Remote Interpreting (VRI), the member can point to the language they speak.

Best practice to capture language preference: For LEP members, it is best practice to capture the member's preferred language and record it in the plan's or provider's member data system. You may want to consider asking the following question:

"In order for (provider's name) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is for discussing health care?"

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

N7: Language Access Program

CenCal Health offers language assistance and interpreter services for qualifying visits, to ensure effective communication during medical encounters for our membership only.

Telephonic and video interpreting services are simple, available 24 hours a day, and free of cost to providers and members. These services can assist with communication between providers and members who do not speak the same language.

To access language services, complete the steps below:

Telephonic Interpreter Services

1. Dial the toll-free number: **800-225-5254 or 503-484-2425**
2. Provide operator customer code: **48CEN**
3. Indicate to the operator that you are calling from: **CenCal Health – Providers**
4. Request the language needed.
5. Provide your name and phone number, provider's last name, NPI #, CenCal Health member ID, and patient name.
6. For languages of lesser diffusion, like Mixteco, it is suggested that appointments be scheduled two weeks ahead of time.

You will need to provide the following information in addition to the information listed above:

1. Date, time, and time zone for the scheduled call.
2. Estimated call duration.
3. Language needed (for **Mixteco**, you must share the name of the **town/pueblo** the member is from).
4. Contact name and phone number.
5. Nature of call.
6. Request to be informed at least three days prior to the appointment if they are unable to cover the appointment.

You will be given:

- A reference number for the appointment.
- A confirmation once an interpreter is secured.
- If CLI is not able to secure an interpreter, you can reach out to the CenCal Health Member Services Department for further assistance by calling 877-814-1861.

Video Remote Interpreting (VRI)

1. Go to the VRI web address: **cencalhp.cli-video.com**
2. Enter your MERFI Access Code: **48cencalhp**
3. Enter required information:
    - Caller's full name
    - Phone number
    - Provider's/Doctor's last name
    - NPI #
    - Member ID #
    - Patient's last name
4. Select the appropriate language to connect to an interpreter via video.
5. Choose the channel: Video
6. For the Schedule field:
    a. Select **No** to connect with an interpreter immediately.
    b. Select **Yes** to pre-schedule an interpreter for a later date.

Face-to-Face Interpreters

Face-to-face interpreter services may be authorized by CenCal Health for members who have conditions that render telephonic or video interpreters ineffective or for members requiring the following CenCal Health-covered services:

a) Services for members who are deaf and hard of hearing (American Sign Language/ASL) who cannot communicate effectively using a Video Remote Interpreter (VRI).
b) Abuse or sexual assault issues.
c) End-of-life issues/Hospice.
d) Complex procedures or courses of therapy.
e) First physical therapy appointment and re-check appointment.
f) First oncology appointment.
g) First orthopedic appointment.

Prior authorization via the Member Services line at 877-814-1861 is required for face-to-face interpreter services requests for those Spanish-speaking members who meet the criteria noted above. CenCal Health encourages providers to coordinate face-to-face interpreter services at least five business days prior to the appointment. Upon authorization of service, the Cultural and Linguistic Services Department will schedule a qualified interpreter for the requested date of service. If no face-to-face interpreter is available to cover the requested date and time, CenCal Health will reach out to the person who made the request to inform them and assist in making other arrangements. For more information regarding Language Assistance, please visit CenCal Health's website: www.cencalhealth.org/providers/cultural-linguistic-resources/.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

N8: Language Assistance

If a member speaks a language other than English, qualified language assistance services are available to providers and members free of charge. CenCal Health recognizes the importance of clear communication with your patients and is committed to assisting you through telephonic, face-to-face, and video remote interpreter services.

Reference Links:

CenCal Health Notice of Availability of Language Assistance Services and Auxiliary Aids and Services:
www.cencalhealth.org/wp-content/uploads/2023/07/Tagline-CenCal-Health-M-MS-HIYL-0623-new.pdf

CenCal Health Cultural and Linguistic Resources
www.cencalhealth.org/providers/cultural-linguistic-resources/

Section O: Provider Complaints and Grievances

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

O1: Provider Complaints and Grievances

CenCal Health has developed a process to address provider complaints and grievances efficiently and fairly. This policy provides an avenue for contracted and non-contracted providers to bring concerns or opportunities for improvement to CenCal Health's attention, thus driving CenCal Health's operations and direction, as appropriate.

Definitions
Complaint: A complaint is a request for assistance, or an expression of dissatisfaction related to non-clinical member issues, aspects of CenCal Health's administration of its programs, or other issues.

Grievance: A formal written expression of dissatisfaction by a provider with any aspect of CenCal Health's operations, except for CenCal Health decisions regarding claims or service authorizations, regardless of whether any remedial action is requested or can be taken.

Procedure
Receipt of Provider Claims Inquiries, Disputes or Appeals, and Authorization Inquiries or Appeals.

If a provider contacts Provider Relations with issues outside their purview (claims inquiries or appeals, authorization inquiries or appeals, clinical or quality of care concerns), the Provider Relations Representative (PRR) will "warm transfer" the caller to the appropriate department. The appropriate department shall address the grievance, unless otherwise requested, and shall review and respond as appropriate.

a) Receipt and Resolution of a Provider Complaint or Grievance:
    i. The Provider Relations Department is charged with the resolution of provider complaints and grievances. The complaint may be related to non-clinical member issues, aspects of CenCal Health's administration of its programs, or other issues. The provider may file a complaint with the Provider Relations Department via telephone call, fax, email, or letter.
    ii. If a complaint has no clinical or quality of care aspect, the PRR determines whether the provider needs routine assistance or would like to file a formal grievance. Formal grievances must be submitted in writing, preferably on the provider's letterhead.
    iii. Informal complaints and requests for routine assistance are addressed by the PRR, with assistance from other staff as needed. Formal written

acknowledgments or resolutions are generally not necessary for these matters.

iv. If the provider submits a written formal grievance, the PRR will notify the Provider Relations Manager, who will send a receipt acknowledgment letter within five business days.

v. The PRR will collaborate with other staff as needed to investigate and resolve the provider's grievance. Following resolution of the complaint, the PRR will document the case and the outcome, and the Provider Relations Manager will send a resolution letter. All grievances are resolved within 45 business days.

Disclosure to Providers and Members

Providers are informed of their right to file complaints and grievances, and the availability of assistance in the filing process, in a variety of ways. This may include, but is not limited to, through their provider contract agreements or amendments, CenCal Health's website, Provider Bulletins, and in provider materials and manuals issued by CenCal Health and updated periodically.

CenCal Health's grievance system is in addition to any other dispute resolution procedures available to the provider. The provider's failure to use these procedures does not preclude the provider's use of any other remedy provided by law.

CenCal Health's Chief Strategic Engagement Officer and Legal Counsel will be notified immediately when a provider's legal representative contacts CenCal Health regarding the pursuit of legal action to resolve a complaint or appeal.

CenCal Health will not discriminate or retaliate in any manner, including but not limited to the cancellation of the provider's contract, against a provider who files a grievance.

Grievances shall be received, handled, and resolved without charge to the provider. However, CenCal Health shall have no obligation to reimburse the provider for any costs incurred in connection with filing a complaint or grievance.

Confidentiality and Privacy Regarding Record Retention

All provider complaints and appeals shall be placed in designated files and maintained by the Provider Services Quality Liaison for at least 10 years after the resolution; the files of the previous two years shall be in an easily accessible place at CenCal Health's offices.

Monitoring of the Process

Reports: The Provider Services Quality Liaison will prepare a quarterly summary of provider complaints and grievances to be presented to CenCal Health's Network Management Committee. The report shall summarize the number and type of provider complaints, grievances, and appeals.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

O2: Member Grievance and Appeal Process

CenCal Health members may file grievances about their experiences with CenCal Health and its Provider Network. They can also request appeals for denied services and coverage determinations. Members also have the right to obtain a copy of their medical records used to make the decisions.

Providers or authorized representatives can offer to help members file a grievance or an appeal. They can also file appeals on their behalf with the member's written consent. The following information explains the process for member grievance and appeal filing.

CenCal Health requests full provider participation during the investigation of grievances and appeals, including timely response to records requests and other requests for information, to assist in completing accurate reviews.

CenCal Health is dedicated to providing member education when necessary, and clear and concise explanations to members in a final resolution letter addressing all concerns raised in the grievance filing.

Non-Delegation of Grievance or Appeal Processes

While many providers have internal policies for resolving internal patient complaints/grievances, CenCal Health provides a Grievance and Appeal System for our members to express their dissatisfaction or to appeal a decision that they do not agree with. We do not delegate any of these activities to our provider network. Please refer the member directly to CenCal Health's Member Services Department to file their grievance or appeal requests, or provide our members with the grievance and appeal forms made available by CenCal Health to your offices.

Important Timeframes for Filing:

For appeals, CenCal Health Medi-Cal members have 60 calendar days, and CenCal CareConnect members have 65 calendar days from the date of the notice of the initial determination to submit an appeal. For requests received after the filing timeframe, good cause must be established for late filing. Members have a right to request continuation of benefits while an appeal is in progress. An appeal or grievance can be made by the member, the authorized representative, or a provider on behalf of the member, with their written consent.

For grievances, there is no longer a time limit to file. Members are encouraged to file grievances as close to the date of incident or concern as possible, but they may request a grievance at any time.

Discrimination Grievances:
These types of grievances are processed by a Discrimination Grievance Coordinator to ensure the health plan is in compliance with federal and state nondiscrimination requirements and to investigate cases related to any action that would be prohibited by, or out of compliance with, federal and state requirements.

Quality Improvement Organization (QIO) Review – CenCal CareConnect Members ONLY

Quality of Care Grievances:
If a CareConnect DSNP member is dissatisfied with the quality of care they have received from a contracted provider/facility, they the right to file a complaint directly with the quality improvement organization (QIO), Commence Health LLC. Commence Health will review their complaint, and a Commence Health Physician Reviewer will determine if mistakes were made or determine if the member received poor quality in the health care received.

Members can contact Commence Health with their health care concerns.

- **Phone:** 1-877-588-1123 (TTY: 711)
- **Fax:** 1-855-694-2929
- **Hours of Operation:** Monday through Friday, 9 a.m. to 5 p.m., PST
- **Saturday, Sunday, and holidays:** 10 a.m. to 4 p.m. (local time)
- A 24-hour voicemail service is available.

Mailing Address:
BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

If a provider or a representative who is NOT the member would like to file a grievance or appeal on behalf of the member, the provider must obtain written consent from the member to do so. This signed consent should be submitted with your appeal request. CenCal Health is able to initiate a grievance or appeal filed by a provider for a member, with at least verbal authorization from the member. DHCS and CMS requires CenCal Health to request written consent even if verbal authorization is obtained, so it is best to obtain written authorization for submission when filing the grievance or appeal request. Copies of these forms are available on the following links:

Medi-Cal Members:
Written Consent to Appeal Form - English
Written Consent to Appeal Form - Spanish
Written Consent Grievance Form - English
Written Consent Grievance Form - Spanish

CareConnect Members:
CareConnect Appointment of Representative Form (CMS1696)-English

CareConnect Appointment of Representative Form (CMS1696) Spanish

How to Assist Members in Filing Grievances or Appeals
A grievance or an appeal can be filed by members or on behalf of members by any of the following methods:

1. By phone: Calling CenCal Health's Member Service Department at our toll-free number 1-877-814-1861.

2. In person: By visiting CenCal Health.

3. By completing a Grievance/Appeal Form and/or submitting in writing to:

For Medi-Cal Members:
CenCal Health
Attn: Grievance & Appeals
4050 Calle Real
Santa Barbara, CA 93110

For CenCal CareConnect Members:
CenCal Health
Attn: CareConnect Grievance & Appeals
4050 Calle Real
Santa Barbara, CA 93110

Medicare Members:
CareConnect Grievance & Appeal Form- English
CareConnect Grievance & Appeal Form- Spanish

Medi-Cal Members:
Member Grievance Form – English
Member Grievance Form – Spanish
Member Appeal Form – English
Member Appeal From – Spanish

Via website at this link: www.cencalhealth.org/members/file-complaint/
https://www.cencalhealth.org/wp-content/uploads/2025/09/D25-26159_Appeal-Grievance-FORM_R3_Fillable_APP-080125-E94.pdfhttps://www.cencalhealth.org/wp-content/uploads/2025/09/D25-26159_Appeal-Grievance-FORM-_Fillable_APP-080115-S39.pdf
CenCal Health also offers members assistance in filing grievances, appeals, or State Fair Hearings, including providing members with any necessary forms and providing auxiliary aids and services, when requested (such as interpreter services or documents in alternative formats).

Standard and Expedited Review Processes

Standard: In most circumstances, grievance or appeal requests will be processed through the Standard Grievance/Appeal Review Process, which allows a 30-day maximum review timeframe.

The standard process includes a written resolution of the grievance or appeal within 30 calendar days of filing. Standard Part B drug appeals allow a maximum 7-day timeframe for review.

Effectuation of most Part C level types, including Part B drug-related cases, will occur within the case resolution timeframe.

Expedited: An expedited review of a grievance or appeal can be requested in certain cases, which allows a 72-hour timeframe from the day it is received and consented to by the member. This process supports resolution of the appeal within 72 hours when a delay in a decision using the 30-day standard process may seriously jeopardize the member's life, health, or the ability to attain, maintain, or regain maximum function. A CenCal Health physician reviewer will determine if the appeal request meets expedited criteria for processing, if requesting an expedited grievance or appeal.

If the expedited process is granted, a physician reviewer who was not involved in the original decision will complete the review, and the resolution of that appeal will be provided verbally to the requester within 72 hours of filing. Written notification is also provided within 72 hours in most cases; however, it can be delayed for translation needs.

If the CenCal Health Physician Reviewer determines the appeal does not meet expedited criteria for processing, the process will revert to the standard appeal process for resolution. Attempts will be made to verbally notify the member or authorized representative of this change to a standard 30-day process, and the verbal notification is also followed by a written Acknowledgement Letter initiating within five calendar days the standard grievance or appeal.

Medicare Independent Review Entity (IRE) Process – CenCal CareConnect Members ONLY

Upon CenCal Health's denial of a member's appeal for a D-SNP covered service or benefit, CenCal Health must auto-forward the denial and all the information used to make the decision to the Medicare Independent Review Entity (IRE). Members will not need to do anything to receive this secondary review. Our plan will **automatically** send the case to the IRE for a Level 2 appeal. The IRE is an organization that isn't connected or contracted with CenCal Health. The IRE will contact the requester of the appeal/member to gain more information about the appeal if needed. The IRE will mail an answer of agreement or overturn within 30 calendar days from when it receives the appeal. In some cases, it may be sooner.

An enrollee, an enrollee's representative, or a non-contracted provider may request from the IRE a reconsideration of a Plan dismissal of an appeal. The request must be filed with the IRE within 65 calendar days from the date of the Plan dismissal decision notice. The request must be made in writing, which includes fax. The request must be sent to the IRE, C2C Innovative Solutions, at:

C2C Innovative Solutions
Fax: 904-539-4076

Expedited and Part B Drug Reconsiderations UPS / FedEx Only

C2C Innovative Solutions, Inc. - QIC Part C
Attn: QIC Part C – Expedited OR
Attn: QIC Part C – New Appeals
301 W. Bay St., Suite 1110 Jacksonville, FL 32202

All Other Reconsiderations United States Postal Service (USPS)
C2C Innovative Solutions, Inc. - QIC Part C
Attn: QIC Part C – New Appeals
P.O. Box 1949
Jacksonville, FL 32231-0053

Medi-Cal State Fair Hearing Process for Members
Upon CenCal Health's denial of a member's appeal for a Medi-Cal covered treatment or service, members have a right to request a State Fair Hearing. Members may request the State Fair Hearing from the Department of Social Services (DSS) within 120 days of the date of the Notice of Appeal Resolution Letter (NAR) they received from CenCal Health denying the member's appeal for a treatment or service.

Medi-Cal members can ask for a State Fair Hearing by phone or in writing at:

California Department of Social Services
State Hearings Division
744 P. Street, MS 9-17-433
Sacramento, CA 95814
Phone: 1-800-743-8525 (Voice) or 1-800-952-8349 (TDD/TTY)
Fax: 1-833-281-0903
Online at: www.cdss.ca.gov

State Fair Hearing Request Forms are attached to NAR Letters. Members have a right to request continuation of benefits while a State Fair Hearing is in progress. Members may have representation at hearings. If the member needs an interpreter, an interpreter will be provided at no cost.

If the case is presented at a hearing before a DSS administrative law judge, the DSS judge generally makes a final decision within 90 days from the date of filing a request for hearing or within three business days if an expedited hearing is granted.

Provider Responsibilities

Providers must cooperate with CenCal Health in identifying, processing, and resolving all member grievances and appeals.

Cooperation in this process includes, but is not limited to:

- Speaking with CenCal Health Grievance & Appeals Coordinators to assist with resolving the grievance or appeal in a reasonable manner.
- Having designated staff available for grievance and appeal investigation.
- Completing a written provider response, if requested. Providers may choose to respond in writing at any time within the investigation period as well, and often provide written documentation of their requests when filing on a member's behalf.
- Responding timely to all information/documentation requests made by CenCal Health related to the grievance or appeal: medical record requests, provider's response to the complaint, scheduling documentation/ phone logs, and/or other supporting documentation needed for CenCal Health's review.
- Responding to requests in a timely manner (within seven calendar days at a maximum) from the date of the notification.

CenCal Health's Grievance & Appeal Team is available to answer any questions you may have about this process at any time. Please contact us through the Member Services Call Center at 1-877-814-1861 and ask to speak with a Grievance & Appeal Coordinator.

Section P: Health Education and Information

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

P1: Health Education Services

CenCal Health members are eligible to receive point-of-service health education services at no charge as part of preventive and primary healthcare visits. Health risk behaviors, health practices, and health education needs related to health conditions should be identified, and educational interventions, including counseling and referral for health education services, should be conducted and documented in the member's medical record.

A variety of educational strategies, methods, and materials should be used that are appropriate for the CenCal Health member population and that are effective in achieving behavioral change for improved health.

Resources and Support for Providers

CenCal Health can assist you with developing and delivering culturally and linguistically appropriate health education materials and interventions for your patients, as well as collaborate with you to educate patients about the importance of screening, particularly in underserved populations.

CenCal Health can provide education, training, and program resources to assist in the delivery of health education services for your patients.

For information to support health education services in your practice, contact the Health Promotion team at healthed@cencalhealth.org or 800-421-2560, ext. 3126.

Resources for CenCal Health Members

CenCal Health members can be referred to the Health Education Request Line at 800-421-2560, ext. 3126, or to their Member Portal account to request specific materials or other health education needs from CenCal Health.

CenCal Health's online library of patient education materials (linked below) is available to members at no cost, in English and Spanish, on the Health and Wellness section of our website.

CenCal Health members can also access evidence-based self-management tools on our website (linked below) for the management of conditions or behaviors. These self-management tools are interactive resources that allow members to determine risk factors, provide guidance on health issues, recommend ways to improve health, or support reducing risk or maintaining low risk.

A Digital Health Literacy Educational program is available to members who would like to learn about using online health portals or phone applications for managing their health.

CenCal Health also produces health education materials and videos for member and provider use.

If you would like to utilize any of the described resources in your practice, please contact the Health Promotion team at healthed@cencalhealth.org or 800-421-2560, ext. 3126.

Reference Links:

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

www.cencalhealth.org/health-and-wellness/self-management-tools

www.cencalhealth.org/health-wellness/digital-health-literacy/

Section Q: Fraud Waste and Abuse (FWA) & Protected Health Information (PHI)

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

Q1: Overview of Fraud, Waste, and Abuse

CenCal Health is committed to detecting, investigating, preventing, and reporting suspected or actual fraud, waste, and abuse (FWA). CenCal Health's Anti-Fraud Program is designed to help identify and address suspected or actual FWA. The Fraud Prevention Office, within the Compliance Division, reviews and investigates reports of suspected or actual FWA and works with state and federal agencies, as well as law enforcement, when appropriate.

CenCal Health maintains multiple reporting channels for suspected or actual FWA, including an anonymous reporting hotline. CenCal Health's website also includes information for members and providers about identifying and reporting potential or actual FWA. The website highlights many of the same elements included in this manual, including:

- A definition of FWA.
- Information reporters should provide to support an investigation.
- How to report potential or actual FWA.

For more information on FWA, please visit our CenCal Health website page on fraud at www.cencalhealth.org/providers/suspect-fraud.

Under the terms of the contract between CenCal Health and its provider network, providers must promptly report suspected or actual FWA to CenCal Health through established reporting channels. Providers and subcontractors should include enough information to support review and investigation, while protecting protected health information (PHI) and sharing only the minimum necessary information. This section of the Provider Manual provides general guidance for providers and subcontractors in identifying and reporting FWA to CenCal Health.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

Q2: Fraud, Waste, and Abuse (FWA) Definitions

Fraud: An intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person, and includes any act that constitutes Fraud under applicable federal or state law, including 42 CFR section 455.2 and W&I Code section 14043.1(i).

Waste: The overutilization or inappropriate utilization of services and misuse of resources.

Abuse: Practices that are inconsistent with sound fiscal and business or medical practices and result in unnecessary cost to the Medicare or Medi-Cal (Medicaid) programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes member practices that result in unnecessary costs to the Medicare or Medi-Cal (Medicaid) programs.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

Q3: Health Care Examples of Fraud

CenCal Health is dedicated to preventing, detecting, investigating, and reporting suspected or actual fraud, waste, and abuse (FWA). CenCal Health relies on its plan partners, including network providers, to help identify and report suspected or actual FWA.

The examples below are not a complete list. Suspected or actual FWA must be reported to CenCal Health. When in doubt, report suspected FWA so CenCal Health can review the concern and take appropriate action

Examples Involving Members, Beneficiaries, or Recipients

- Allowing a caregiver, family member, or attendant to claim hours for personal care services when the services were not provided, or signing time sheets or visit records that are inaccurate.
- Selling, sharing, or allowing another person to use your Social Security number or health plan ID number to obtain benefits.

- Using medical or non-medical transportation for non-healthcare needs, non-covered services, or when there is no appointment or prescription to pick up.

Examples Involving Providers

- Billing for medically unnecessary services to maximize reimbursement rather than meet the member's clinical needs.
- Offering gift cards, free items, discounts, or services to influence a member's choice of provider.
- Prescribing more medicine than is medically necessary or appropriate for the member's condition.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

Q4: Reporting Fraud, Waste, or Abuse (FWA)

CenCal Health's contracts with providers and subcontractors require contracted entities to report suspected Fraud, Waste, and Abuse (FWA) within 10 business days from the date they first become aware of, or are placed on notice of, the suspected activity. Federal law also requires identified overpayments to be reported and returned to CenCal Health within 60 calendar days after the date the overpayment is identified. CenCal Health supports good-faith and anonymous reporting through multiple reporting channels available to employees, members, business partners, providers, subcontractors, and the public. Reports may be made without fear of retaliation.

When reporting suspected FWA, please provide as much of the following information as possible, if available and applicable:

- **Actor or suspect identification and contact information:** Name, address, license or insurance ID, Member ID, or other identifying information.
- **Incident description and details:** A clear description of what happened, including who was involved, what occurred, where and when it occurred, and the date and time of the incident, if known.
- **Supporting documentation:** Any records, documents, correspondence, screenshots, or other information related to the suspected incident.
- **Reporter contact information:** Your name and telephone number, if you would like CenCal Health to contact you for follow-up. Anonymous reports are also accepted.

Any person may report suspected FWA to CenCal Health using one of the reporting options below. Reports may be made anonymously, and CenCal Health prohibits retaliation against anyone who reports a concern in good faith.

CenCal Health FWA Reporting Contacts		
Reporting Channel	Contact Information	Contact Details
☎ **FWA Hotline (Phone)**	866-775-3944	The FWA Hotline is operated by a third-party vendor on behalf of CenCal Health. The hotline: • Operates 24 hours a day, 7 days a week; • Maintains reporter confidentiality; • Offers anonymous reporting; and • Provides reporting support in English and Spanish.
Online	https://cencalhealth.alertline.com/gcs/overview	This online reporting system is hosted by a CenCal Health vendor. **To file a report:** 1. Click the link or enter the URL into your browser. 2. Select "Make a Report" at the top of the web page. 3. After completing your report, you will receive a unique "report key." 4. Write down your report key and password and keep them in a safe place. 5. After five to six (5-6) business days, use your report key and password to check for feedback or follow-up questions.
Email	compliance@cencalhealth.org	If the report contains protected health information (PHI), please send it by secure email.
Mail	CenCal Health Fraud Prevention Office Compliance Division 4050 Calle Real Santa Barbara, CA 93110	
Fax	805-681-8279	Please send fax reports to "ATTN: Compliance Department."

☎ **Chief Compliance Officer and Fraud Prevention Officer (Phone)**	877-814-1861	This is CenCal Health's toll-free number. When speaking with a Member Services Representative, ask to speak with the Chief Compliance Officer because you would like to report suspected Fraud, Waste, or Abuse.

Government Agencies & CenCal Health Regulators FWA Reporting Contacts

Medi-Cal Services - Department of Health Care Services (DHCS)	
☎ **Phone**	800-822-6222
Online	www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx
Medi-Cal Services - California Department of Justice, Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA)	
☎ **Phone**	800-722-0432
Online	https://oag.ca.gov/bmfea/reporting
Medicare and Medi-Cal Services - Health and Human Services (HHS) Office of Inspector General (OIG)	
☎ **Phone**	800-HHS-TIPS (800-447-8477)
Online	https://oig.hhs.gov/fraud/report-fraud

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

Q5: Investigation of Fraud, Waste, or Abuse (FWA)

CenCal Health identifies, reviews, investigates, and responds to allegations of suspected fraud, waste, or abuse (FWA) from members, providers, regulators, and CenCal Health employees. Investigations are conducted in a timely, objective, well-documented, and confidential manner, consistent with applicable laws, regulations, contracts, and CenCal Health policies. Investigations into suspected FWA are performed by the Fraud Prevention Office and overseen by CenCal Health's Chief Compliance and Fraud Prevention Officer.

During the investigation process, CenCal Health may review claims, medical records, billing documentation, encounter data, and other relevant information to determine whether services billed were medically necessary, properly documented, delivered by the provider, and received by the member. Providers are expected to cooperate with investigation-related requests, which may include providing access to medical records and billing documents on a prepayment or post-payment review basis, participating in on-site audits, responding to interviews, and submitting other supporting documentation requested by CenCal Health. If a provider does not submit requested records, refuses access, or otherwise does not cooperate with the investigation, CenCal Health may deny payment, recover payment, or take other appropriate action as permitted by law, regulation, contract, or policy.

If CenCal Health determines that FWA occurred, the provider will be notified of the findings in writing, including an explanation of any identified overpayment. The provider may be required to repay the amount through a one-time payment, payment plan, or offsets to future claims payments, as determined by CenCal Health and as directed or permitted by applicable federal or state law, regulation, or contract.

Investigations and cases shall be approved for closure after final review of the case documentation, supporting data, investigative steps, and findings by the Chief Compliance and Fraud Prevention Officer and/or designee. Investigation information shall be maintained confidentially and shared only with individuals who have a business, legal, contractual, or regulatory need to know. The provider may have the right to dispute the results of the investigation.
The Sr. Compliance Investigator, in collaboration with the Chief Compliance and Fraud Prevention Officer and/or designee, shall determine the appropriate corrective action and remediation steps to address identified issues and prevent or deter future FWA. Potential remediation steps may include, but are not limited to: (i) termination of the provider contract, (ii) revocation of delegated activities, (iii) additional prepayment or post-payment review of claims, (iv) enhanced monitoring, reporting, or educational requirements, (v) recovery of overpayments, or (vi) referral to the Health and Human Services Office of Inspector General, DHCS Program Integrity Unit, CMS, and/or law enforcement, as required or permitted by law, regulation, contract, or policy.

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

Q6: Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that requires CenCal Health and its network providers to protect the security and confidentiality of members' Protected Health Information (PHI) and to provide members with certain privacy rights.

PHI is any individually identifiable health information, including demographic information. PHI includes but is not limited to a member's name, address, phone number, medical information, social security number, ID card number, date of birth, and other types of personal information.

This section of the Provider Manual provides guidance to help providers:

a) Implement safeguards to protect CenCal Health member PHI;
b) Use and disclose PHI appropriately;
c) Maintain required privacy and confidentiality policies and procedures;
d) Provide members with timely access to their PHI;
e) Comply with confidentiality and privacy provisions under Network Provider Agreements; and
f) Identify and report privacy incidents and breaches to CenCal Health.

Safeguarding PHI

As HIPAA-covered entities, CenCal Health and its network providers must comply with HIPAA requirements. Below are a few reminders on how to protect and secure PHI:

PHI in Paper Form

- Documents containing PHI should not be visible or accessible to visitors or others who are unauthorized to have access to PHI.
- When faxing documents containing PHI, verify the recipient, the recipient's fax number, and the documents being sent.
- Ensure that outgoing faxes include a fax cover sheet that contains a confidentiality statement.
- When mailing PHI, verify the recipient, the recipient's mailing address, and the documents being sent.
- Ensure that envelopes and packages are properly sealed and secured, and if using a clear window envelope, ensure that information is not visible through the window of the envelope prior to mailing out.
- When transporting PHI, ensure that the information is protected by using binders, folders, or protective covers.
- PHI must not be left unattended in vehicles.
- PHI must not be left unattended in baggage at any time during traveling.
- PHI should be locked away during non-business hours.

- PHI must be properly disposed of by shredding. Never recycle or dispose of documents containing PHI in the trash bin.

PHI in Electronic Form

- When transmitting PHI via email, ensure that the email is encrypted; this prevents anyone other than the intended receiver from obtaining access to the PHI.
- Do not include PHI, such as an individual's name or Beneficiary ID number (CIN), in the subject line of the email.
- Confirm the recipient, recipient's email address, and documents or information being sent, prior to sending the email.
- Ensure all portable data storage devices (CDs, DVDs, USB drives, portable hard drives, laptops, etc.) are encrypted.

PHI in Oral Form

- Do not discuss PHI in public areas, such as the patient waiting room.
- Do not discuss PHI with unauthorized people. Always verify the identification of an individual prior to discussing PHI with the individual.
- Ensure you speak quietly when discussing PHI.

Uses and Disclosures of Member PHI

The HIPAA Privacy Rule allows member PHI to be used and disclosed without the member's written consent for the following reasons (not a complete list):

- Verifying eligibility and enrollment
- Authorization for Covered Services
- Claims processing activities
- Member contact for appointments
- Investigating or prosecuting Medi-Cal cases (e.g., fraud, waste, or abuse)
- Monitoring Quality of Care
- Medical treatment
- Case Management/Disease Management
- Providing information to public health agencies as permitted by law
- In response to court orders or other legal proceedings
- Appeals/Grievances
- Requests from state or federal agencies or accreditation agencies

Providers must obtain a valid HIPAA-compliant authorization for uses and disclosures of PHI that do not fall within the permitted purposes listed above or are not otherwise permitted by the HIPAA Privacy Rule.

Policies and Procedures

Providers must have policies and procedures in place to guard against unlawful disclosure of PHI, Personal Information (PI), and any other confidential information to any unauthorized persons or entities. Examples of policies and procedures include, but are not limited to:

- Uses and Disclosures of PHI

- Minimum Necessary Disclosures of PHI
- Authorization for Release of PHI

Member Access to PHI
The HIPAA Privacy Rule requires CenCal Health and its network providers to provide members, upon request, with access to their PHI. Providers must ensure that their medical records systems allow for prompt retrieval of medical records and that these records are available for review whenever a member requests access to their PHI. Providers must also ensure to provide the member with both timely access to their PHI and provide the PHI in the form and format requested by the member.

Confidentiality and Privacy Provisions Under Network Provider Agreements
Providers are required to comply with all provisions of Confidentiality of Information in their Network Provider Agreements.

Confidentiality of Gender-Affirming Care Records
Providers must comply with all applicable federal and California confidentiality and privacy laws, including California Civil Code § 56.109 relating to legally protected health care activity. Under California law, medical information related to an individual seeking, obtaining, providing, or facilitating lawful gender-affirming health care or gender-affirming mental health care may be subject to additional disclosure restrictions under California law.

Providers shall not release medical information related to gender-affirming health care or gender-affirming mental health care in response to requests, subpoenas, investigations, or legal processes when disclosure is prohibited by California law. This may include out-of-state requests originating from another state that seek to interfere with an individual's right to obtain lawful gender-affirming care in California.

Providers shall not cooperate with requests for medical information related to lawful gender-affirming care when disclosure is prohibited under California law. Before responding to any subpoena, records request, investigation, or inquiry involving records related to gender-affirming care, providers should review applicable legal requirements and consult with legal counsel as appropriate.

Providers are responsible for maintaining policies, procedures, workforce training, and safeguards necessary to protect confidential medical information and comply with all applicable privacy and confidentiality requirements.

Reporting Privacy Incidents and Breaches to CenCal Health
The HIPAA Breach Notification Rule requires CenCal Health and HIPAA-covered entities to provide notification following a breach of PHI. Providers must report privacy incidents and breaches involving CenCal Health members to CenCal Health immediately, and no later than 24 hours after discovery.

A privacy incident is defined as an event or situation where an individual or organization has suspicion or reason to believe that PHI may have been compromised. Privacy incidents include but are not limited to the following:

- PHI sent to the wrong individual or organization.
- PHI being sent unencrypted.
- Loss or theft of documents containing PHI.
- Loss or theft of unencrypted devices (laptop, hard drives, USB drives).

A breach is defined as an unauthorized access, use, or disclosure of PHI that violates federal or state laws or PHI that is reasonably believed to have been acquired by an unauthorized person.

Timely reporting of incidents and breaches involving member PHI is critical to support response, investigation, and mitigation. Providers may report suspected or known privacy incidents and breaches to CenCal Health using any of the following methods:

Reporting Method	**Contact Information**
Phone	Anonymous Compliance Hotline: 866-775-3944
Online	https://cencalhealth.alertline.com/gcs/overview
Email	HIPAATeam@cencalhealth.org
Fax	805-681-8279
Mail	CenCal Health, Attn: Privacy Office, 4050 Calle Real, Santa Barbara, CA 93110

Reference Links:

U.S. Department of Health and Human Services- HIPAA for Professionals: www.hhs.gov/hipaa/for-professionals/index.html

DHCS Data Privacy: www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx

This section applies to the following CenCal Health programs:

Medi-Cal, CenCal CareConnect (HMO D-SNP)

Q7. Text Messaging with Members

Providers that communicate with CenCal Health members by text message, including SMS, MMS, automated reminders, or vendor-supported texting platforms, must comply with all applicable privacy, security, consumer-contact, and confidentiality requirements, including yet not limited to, the Health Insurance Portability and Accountability Act (HIPAA), California Confidentiality of Medical Information Act (CMIA), Telephone Consumer Protection Act (TCPA), Centers for Medicare & Medicaid Services (CMS) requirements, California Department of Health Care Services (DHCS) requirements, and CenCal Health contract requirements.

Text messaging may be used only when lawful, appropriate for the member's needs and preferences, and supported by reasonable safeguards to protect member information.

Provider Requirements

- Obtain and document any legally required member consent before sending text messages. Consent may not be assumed solely because a member provided a telephone number.
- Honor member communication preferences and provide a clear way for members to opt out of text messages.
- Use the minimum necessary information in messages, and avoid including PHI, diagnoses, treatment details, Social Security numbers, member identification numbers, or other sensitive information unless legally permissible and necessary.
- Use another way to contact the member if texting could put their privacy, confidentiality, or safety at risk. This includes messages about sensitive services or confidential communication requests.
- Verify the phone number before sending member-specific information.
- Maintain appropriate policies, procedures, training, and oversight for text messaging activities.

Vendors, Documentation, and Incident Reporting

Providers using a third-party vendor or texting platform are responsible for ensuring the vendor complies with applicable privacy, security, and contractual requirements, including execution of a Business Associate Agreement (BAA), when required. Providers must maintain records of required consent, opt-out requests, vendor arrangements, training, and approved message content, as applicable.

Providers must promptly investigate, mitigate, and report suspected or known privacy or security incidents involving text messaging, including misdirected messages, unauthorized disclosures, use of unauthorized platforms, or messages sent after a member has opted out.

Incidents involving CenCal Health members must be reported to CenCal Health immediately by emailing HIPAATeam@cencalhealth.org, and no later than 24 hours after discovery, consistent with Provider Manual requirements and applicable law.

Section R: Pharmacy

This section applies to the following CenCal Health programs:

Medi-Cal

R1: Medi-Cal Rx – Medi-Cal's Pharmacy Benefit

CenCal Health members' Medi-Cal pharmacy benefit is provided through the Department of Health Care Services (DHCS) and runs under the name **Medi-Cal Rx**.

Medi-Cal Rx is administered through DHCS and its vendor, Prime Therapeutics State Government Solutions, LLC. Prime Therapeutics provides a comprehensive suite of administrative services as directed by DHCS, which includes claims management/adjudication, utilization management, and customer support.

Medi-Cal Rx is responsible for administering the following when **billed by a pharmacy on a pharmacy claim form**:

- Covered Outpatient Drugs, including Physician-Administered-Drugs (PADs)
- Medical Supplies
- Enteral Nutritional Products

Medi-Cal Rx does not include pharmacy services billed as a medical (professional) or institutional claim. Pharmacy services, including Physician-Administered-Drugs, billed on a medical claim, are the responsibility of CenCal Health.

Information regarding the Medi-Cal Rx formulary, prior authorization process, and Provider Portal can be accessed directly from the DHCS Medi-Cal Rx website.

Medi-Cal Rx reviews and adjudicates pharmacy prior authorization requests. A response is provided to the submitting provider within 24 hours of receipt of the PA request, in accordance with DHCS requirements.

The Medi-Cal Rx customer service center can be reached directly at 1-800-977-2273.

The CenCal Health Pharmacy team is also available to answer any questions regarding Medi-Cal Rx at 805-562-1080

Reference Links:

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

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

This section applies to the following CenCal Health programs:

Medi-Cal

R2: Medical Pharmacy, Authorizations for Physician-Administered-Drugs (PADs)

CenCal Health and the Pharmacy Services Department are responsible for a variety of activities, including, but not limited to:

- Clinical pharmacy adherence
- Drug Utilization Review (DUR)
- Utilization management associated with pharmacy services (physician-administered drug) billed on a medical and institutional claim.

CenCal Health defines the utilization management of physician-administered drugs on the medical benefit as **Medical Pharmacy Management**. Medical Pharmacy Management includes clinical guideline criteria, physician-administered drug authorization request review, and preferred medical pharmacy drug programs.

A comprehensive overview of the Medical Pharmacy Program can be found on the CenCal Health Pharmacy Services webpage. In addition, instructions on how to submit an authorization request through the medical benefit can be found on the CenCal Health Authorizations webpage.

Reference Links:

CenCal Health Pharmacy Services
www.cencalhealth.org/providers/pharmacy/medical-pharmacy-management/

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

This section applies to the following CenCal Health programs:

CenCal CareConnect (HMO D-SNP)

R3: CenCal CareConnect Formulary

This section outlines the formulary policies for CenCal CareConnect, which integrates Medicare and Medi-Cal pharmacy benefits for dual-eligible members. The formulary is intended to ensure access to safe, effective, and cost-conscious prescription drug therapies while maintaining compliance with federal and state regulations.

Formulary Management and Oversight
The CenCal CareConnect Formulary is reviewed and maintained by the CenCal Health Pharmacy and Therapeutics (P&T) Committee, composed of community-based pharmacists and physicians from diverse specialties. The committee meets quarterly to review formulary recommendations, clinical guidelines, safety alerts, and to evaluate new drugs. Decisions are based on clinical efficacy, comparative effectiveness, cost, and alignment with Medicare and Medi-Cal requirements.

Accessing the Formulary
Providers may access the most current versions of the CenCal CareConnect Rx formularies online:

CenCal CareConnect Formulary: www.cencalhealth.org/health-plans/careconnect/cencal-careconnect-materials/ https://medi-calrx.dhcs.ca.gov/
Hard copies are available upon request by contacting the CenCal Health Pharmacy Services Department. See contact information below.

Drug Coverage Responsibilities
Prescription drug coverage for CenCal CareConnect members is generally provided through Medicare Part D. However, Medi-Cal may cover some drugs excluded from Part D, such as select over-the-counter medications, certain vitamins, and drugs used for anorexia, weight gain, or fertility. Medi-Cal also provides cost-sharing assistance. Providers must review both formularies to ensure full coverage for dual-eligible members.

Formulary Tiers and Cost-Sharing
The CenCal CareConnect Formulary follows a six-tier structure to promote affordability and access. Prescribers are encouraged to consider lower-tier alternatives when appropriate:

Tier 1 – Preferred low-cost generics
Tier 2 – Moderate cost generics
Tier 3 – Preferred brands
Tier 4 – Non-preferred brand or higher-cost generics
Tier 5 – Specialty brand & generics
Tier 6 – Select Care Drugs: Medications for chronic conditions with zero cost-sharing

Utilization Management
Certain formulary medications may be subject to prior authorization, step therapy, or quantity limits. These tools help ensure safe and effective use of medications and promote clinical best practices. Non-formulary medications may be covered through the exception process if medical necessity is documented.

Formulary Exception and Prior Authorization
Providers must submit a prior authorization or formulary exception request when a prescribed drug is not on the formulary or fails to meet applicable criteria. Supporting documentation must justify why the member cannot use covered alternatives. Requests are reviewed within applicable Medicare Part D and Medi-Cal required timeframes.

Transition Fills
To minimize disruption in therapy, new members may receive a temporary supply of a non-formulary drug or a drug requiring prior authorization within the first 90 days of enrollment. This allows time for clinical assessment and completion of prior authorization or transition to a covered alternative.

Formulary Updates
Formulary updates are implemented quarterly and posted to the CenCal Health website. Providers are responsible for staying informed of changes that may affect prescribing and member coverage. Changes may include additions, removals, tier shifts, or revised utilization management requirements.

Provider Responsibilities and Billing Reminders

- Do not bill members for medications before prior authorization is attempted and denied.
- Do not tell a member a drug is not covered without first submitting a coverage request.
- All drugs may be considered for coverage unless specifically excluded by CMS or Medi-Cal.
- Providers may be required to reimburse members if incorrect billing occurs.

Contact Information
For formulary, pharmacy benefit, or prior authorization inquiries, contact:

CenCal Health Pharmacy Services
Phone: 1-833-726-0676
Fax: 1-858-790-7100
Website: www.cencalhealth.org

This section applies to the following CenCal Health programs:

CenCal CareConnect (HMO D-SNP)

R4: CenCal CareConnect Pharmacy Prior Authorization (PA)

CenCal Health requires prior authorization (PA) for certain medications under its CenCal CareConnect plan to ensure safe, appropriate, and cost-effective use of prescription drugs. This process supports clinical oversight and helps ensure alignment with Medicare and Medi-Cal requirements

Drugs Requiring Prior Authorization
Certain medications on the CenCal CareConnect Formulary, typically those with safety concerns, high cost, limited clinical indications, or high misuse potential, may require prior authorization. These drugs are designated in the formulary with the following utilization management indicators:

- **PA** – Prior Authorization Required
- **ST** – Step Therapy Required
- **QL** – Quantity Limits Apply

Drugs not listed on the formulary also require prior authorization and are subject to review under the exception process.

Submitting a Prior Authorization Request

Providers must provide all information necessary for the plan to make a timely coverage determination. A plan-specific Prior Authorization (PA) request form is available to assist with complete submissions; however, use of the form is not required. Requests may be submitted by telephone, fax, electronic portal, or in writing. The request should include:

- Member name and identification number.
- Prescriber name, National Provider Identifier (NPI), and contact information.
- Drug name, dosage, and quantity requested.
- Diagnosis and applicable ICD-10 code(s).
- Clinical information supporting the request.
- Documentation of formulary alternatives previously tried, if applicable.

Requests can be submitted via:

Phone: 1-833-726-0676
Fax: 858-790-7100
www.cencalhealth.org

Forms and instructions are available at www.cencalhealth.org.

Timeframes for Review

CenCal Health follows CMS-required processing timeframes for Medicare Part D drugs and Medi-Cal Rx requirements for Medi-Cal-covered drugs.

Request Type	Timeframe
Standard Part D PA	Decision within 72 hours of receipt
Expedited Part D PA	Decision within 24 hours of receipt

Expedited requests must be supported by clinical documentation showing that applying the standard timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function.

Provider Notification and Member Communication

Once a decision is made:

- Providers are notified by fax or phone.
- Members are notified in writing of both approvals and denials.
- Denial notices include the reason for denial, appeal rights, and instructions for filing a coverage determination or appeal.

Written notices comply with CMS and Medi-Cal standards, including clinical rationale, criteria used, and how to request reconsideration.

Coverage Determination and Appeals
If a medication is denied, members or their prescribers may request a **coverage determination**. If the denial is upheld, a **redetermination (appeal)** may be requested. Additional options may include external review by an Independent Review Entity (IRE), depending on the nature of the request.

For dual-eligible members, if a medication is not covered under Medicare Part D but may be available under Medi-Cal Rx, CenCal Health coordinates with Medi-Cal to ensure appropriate access.

Provider Reminders
- Submit complete clinical documentation to avoid delays.
- Avoid billing members directly unless they have signed an Advance Beneficiary Notice (ABN) and coverage has been denied.
- Always consult the formulary and Medi-Cal Rx Contract Drug List before initiating a PA.
- Prior authorization does not guarantee payment. Final determination is based on member eligibility and benefit coverage at the time of service.

Contact Information
For prior authorization questions, forms, or assistance, contact:

CenCal Health Pharmacy Services
Phone: 1-833-726-0676
Fax: 858-790-7100
Website: www.cencalhealth.org/providers/pharmacy/

This section applies to the following CenCal Health programs:

CenCal CareConnect (HMO D-SNP)

R5: Medication Therapy Management (MTM) Program

CenCal Health offers a Medication Therapy Management (MTM) Program to eligible CenCal CareConnect members as part of the Medicare Part D benefit. The MTM Program is designed to optimize therapeutic outcomes by promoting safe and effective medication use, improving adherence, and identifying potential medication-related problems. The program is provided at no additional cost to eligible members.

Eligibility Criteria
CenCal CareConnect members may be eligible for the MTM Program if they meet the targeting criteria, which include:

- Having multiple chronic conditions (minimum of three) from the following CMS core chronic disease categories: Alzheimer's disease or other dementias; bone disease or arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis); congestive heart failure (CHF); diabetes; dyslipidemia (high cholesterol); end-stage renal disease (ESRD); HIV/AIDS; hypertension; mental health conditions (including depression, schizophrenia, bipolar disorder, and other chronic or disabling mental health conditions); and respiratory disease (including asthma, COPD, and other chronic lung disorders).
- Taking multiple Part D medications, including all Part D maintenance drugs (eight or more medications).
- Meeting the annual expected Part D drug cost threshold as calculated by CMS. For coverage year 2027, the threshold is $1,340, based on CMS methodology and updated annually.

Opioid Overutilization Monitoring
CenCal Health offers enhanced MTM services to members who are at risk of adverse events due to opioid overutilization. MTM services are available to members who meet the Overutilization Monitoring System (OMS) criteria, determined by CMS annually to identify Part D members at the highest risk of adverse events or overdose. Members with active cancer-related pain, in hospice, receiving palliative or end-of-life care in a long-term care facility, or with sickle cell disease are exempt from OMS criteria.

CenCal Health may also extend MTM services to additional high-risk members based on clinical indicators such as polypharmacy, recent hospitalizations, transitions of care, or medication adherence concerns. Eligibility is assessed throughout the coverage year, and MTM services are voluntary; members must provide consent before participation.

Program Components
The MTM Program includes comprehensive medication reviews, targeted medication reviews, medication action plans, and provider collaboration to optimize medication therapy and identify potential drug-related problems.

MTM pharmacists may reach out to prescribers to recommend clinically appropriate interventions or adjustments. These communications may include phone calls or faxes to the prescriber's office with information and recommendations concerning a member's drug therapy regimen.

Dual-Eligible Member Coordination
While the MTM Program is a Medicare Part D service, CenCal Health coordinates care with Medi-Cal programs and providers to ensure integrated support for dual-eligible members. This coordination ensures comprehensive care management that addresses both Medicare Part D and Medi-Cal covered services.

Recommendations from MTM reviews may include follow-up with the member's Primary Care Provider, behavioral health provider, or other specialists as needed to ensure continuity of care across both Medicare and Medi-Cal benefits.

Provider Role and Referral
Providers are encouraged to refer eligible members who may benefit from MTM services, particularly those experiencing polypharmacy, frequent hospitalizations, or medication non-adherence. Program participation does not affect coverage or benefits.

The member's Primary Care Provider plays an important role in the provision and coordination of quality care for MTM participants. After a member has completed a medication review with a pharmacist, a letter will be sent with recommendations to the member's Primary Care Provider to ensure optimal medication management and continuity of care.

Contact Information
For questions about coordinating member care in conjunction with the MTM program, or to refer a member for MTM services, please contact:

CenCal Health Pharmacy Services
Phone: 1-833-726-0676
Fax: 858-790-7100
Website: www.cencalhealth.org/health-plans/careconnect/medication-therapy-management-mtm/

Section S: Forms Library

S1: Forms Library

CenCal Health offers a comprehensive Forms Library that provides easy access to most forms utilized by our organization. Some forms may require providers to log in to the secure section of our website for access.

The Forms Library includes resources on a variety of important topics, such as:

- Authorizations
- Behavioral Health
- Contracting/Credentialing
- Claims
- Health Education
- Member Resources
- Cultural & Linguistic Resources
- Fraud and Abuse Reporting
- Cultural Competency, Health Literacy & Seniors and Persons with Disabilities
- Community Supports
- Community Health Worker Benefit
- Doula Benefit

For more detailed information, please visit our Forms Library at www.cencalhealth.org/providers/forms-manuals-policies/forms-library/ on the CenCal Health website for more details.