How to Use Our Online Provider Portal

CenCal Health Website Guide
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INTRODUCTION

Welcome to the CenCal Health Website. The Website contains many interactive capabilities such as member eligibility verification, authorization request claim submission, and report requests. It also contains a wealth of reference materials and links to other useful websites. CenCal Health encourages all contracted providers to explore the site for relevant topics for their practice and business.

CenCal Health has many Website demonstrations throughout Santa Barbara and San Luis Obispo County to introduce and train providers on its features. The following document contains step-by-step instructions on how to access and utilize its many features. Remember, websites are not static documents they are updated and changed constantly to meet the needs of users, to improve functionality, and to meet nationally recognized standards and regulations in healthcare.

If anyone has questions or comments about the Website, or would like training, please contact the Provider Services Department by phone at 805.562.1676 or via email providerservices@cencalhealth.org

BEFORE YOU BEGIN

Some of the pages of the CenCal Health’s Website are in PDF formatted files. You must have Adobe Acrobat or similar software to view these files. Adobe Acrobat is free software that you may download from the Internet. CenCal Health’s homepage has a link to Adobe’s Website that you may select in order to download the most recent version of this PDF reader. As a side note, using the Search Icon on the Adobe Acrobat tool bar allows you to search PDF files. The Search icon looks like a pair of binoculars.

Basic prerequisites include a working knowledge of your Internet Browser software, standard Windows menus and commands, and the system requirements of your computer. You should also know how to open, navigate, and close website pages. For more information on your Internet Browser software, please refer to the documentation provided with that software.
THE HOMEPAGE AND NAVIGATING THE SITE

Pictured below is what you will see after you have typed the address www.cencalhealth.org into your web browser. The first page of every website is called “the homepage,” and it is what you will see when you first go into a site. CenCal Health’s Website homepage is a bright and colorful “Welcome” to all visitors.

Once you are here, you have many options to choose from along the top of the page. When you move your mouse cursor around the page, you will notice that the arrow changes into a “hand”, which means you may click on that item to go to that page. It will look like this:

Also, any text that is underlined and/or highlighted may be selected to take you to another page within the Website. If you go to a page and wish to return to the Homepage, you may simply click on the CenCal Health logo at the top of the left hand menu.

The purpose of this guide is to act as an instruction manual for the section titled For Providers. To access this section, simply click on the underlined title in the left column of the homepage.
FOR PROVIDERS

Once you have selected the Providers option, you will see this page:

![.providers_image]

As you can see, there are many reference materials for our providers listed here.

**PROVIDER PORTAL (RESTRICTED)** This section will prompt you to enter your User Name and Password for access. For additional information please reference page 8 of this guide.

**ELIGIBILITY** It is important to verify eligibility before every patient visit. Learn how on this page.

**AUTHORIZATIONS** Depending on the services being provided the authorization type may vary depending on your practice. Below are links to website tools and documents to aid you in understanding what is needed and how to acquire authorizations for members.

**PHARMACY** CenCal Health Pharmacy Services provides a comprehensive pharmacy benefit that includes formulary management, a robust pharmacy network, and quality customer service.

**PROVIDER BASICS** This page is helpful when first contracting with CenCal Health, we walk you through our plans, provide information on Interpreter Services, Provider Incentives, and information on our Behavioral Health benefit.

**CLAIMS** CenCal Health’s claim and billing requirements vary slightly by whether a member is covered under its Medi-Cal programs or one of its other health care programs. The member’s health insurance card will indicate which health care program they are receiving coverage from. This section will give you all the information you need to know about claims and how to bill by electronically and by paper submissions.

**SEARCH PROVIDER NETWORK** Search our network of over 300 Primary Care Physicians and 1300 Specialists to find the medical care that best fits your needs. Our list of participating providers consists of physicians, hospitals, laboratories and pharmacies. We have made every effort to ensure that this list is accurate. The provider details are based upon information received by contracted providers.
CULTURAL AND LINGUISTIC RESOURCES  CenCal Health believes in the importance of providing services in the language of choice for our membership. We recognize the importance of clear communication with your patients and committed to assisting you through telephonic, face-to-face interpreter services and more. Interpreter Services are just a phone call away!

FORMS, MANUALS, & POLICIES We encourage providers to become familiar with the contents of the Provider Manual and to refer to it frequently. These documents include detailed information about your administrative responsibilities, contractual and regulatory obligations, and best practices for interacting with our members. We also provide links to our most frequent forms used by CenCal Health. Some forms may require providers to log in to the restricted section of the website to access.

CASE MANAGEMENT  Case Management (CM) services are provided by registered nurses, social workers, and transitional care coordinators.

DISEASE MANAGEMENT PROGRAMS  CenCal Health identifies members with certain chronic conditions, and develops programs to address their health care needs. These programs work with primary care physicians and specialists to improve clinical outcomes, reduce or delay long-term complications, and improve their health and well-being.

PATIENT EDUCATION MATERIALS  We strive to support you in providing effective health education to our members. All health education materials should be at an appropriate reading level (6th grade or less). We have provided handouts and information here that you can use in your practice. You can also find health education materials in English and Spanish by using our website resource list.

QUALITY OF CARE  Under this section, providers will find information on our Quality Improvement Activities, Clinical Guidelines and Criteria, HEDIS Reports, and more. This information is produced by our Decision Support Department under the guidance of CenCal Health's Medical Director. Every attempt is made to keep the latest healthcare industry standards at your fingertips.

JOIN OUR NETWORK  CenCal Health has always strived to bring the best care possible to members of the programs we administer. Like most managed care organizations, we have a quality of care program designed and implemented to continually improve the health plan and the delivery of health care to our members. As part of this program, we credential and contract with providers practicing as individuals or belonging to groups.

PROVIDER BULLETIN  Each month, the Provider Services Department publishes and mails a Provider Bulletin to each of our contracted providers. It includes information on new programs, changes to member benefits, educational opportunities, claims related detail and more.
**SEND US FEEDBACK** We want to hear what you like and what you think we could do better. CenCal Health’s success is a reflection of our partnerships with local health care providers. Together, we share the goal of delivering quality of service to our network and members.

**PROVIDER TRAINING & RESOURCES** CenCal Health provides workshops for our provider partners on a variety of topics including updated guidelines, policies, new programs and instruction on using our web tools. On this page you can RSVP for upcoming trainings and see material from past events.

**FILE A GRIEVANCE** We understand the need for our provider partners to voice their concerns in a formal manner and receive a written response on the outcome.

**FRAUD, WASTE, & ABUSE** CenCal Health believes in continually improving the healthcare delivery system and part of this is through detecting, correcting and preventing fraud, waste and abuse. You can help stop fraud, waste and abuse by reporting your concerns to CenCal Health anytime you feel any of these may be occurring.

**UPDATE PROVIDER PROFILE** Up-to-date provider information is important to make sure claims are paid efficiently, that your mail reaches you, and your practice is listed accurately in our Provider Directory for members.

**PROVIDER PORTAL (RESTRICTED)**

This area is “restricted” to authorized users only. Providers may only gain access after they have contacted our Webmaster and received a password. **You must have a password to access the eligibility verification, authorization requests, submit claims, and the report sections of CenCal Health’s website.** These areas are not available to our members/subscribers or the general public.

To obtain a password for your office, send an email to providerservices@cencalhealth.org. Be sure to include the provider’s name, Tax Identification Number and National Provider Identifier (NPI), an e-mail address for authorizations, and the point of contact staff member. When the Webmaster contacts you, he/she will ask you for your Tax Identification Number as a means of verification. **CenCal Health encourages our providers to keep this password secure and to change it whenever they have a change in staff. CenCal Health will not be held responsible for any erroneous use of a provider's password. You must make every effort to secure it.**

If you bookmark any of the restricted pages on your web browser, you will still be prompted to enter your User Name and Password each time you log in before gaining access to those pages.
NOTE: For larger provider groups, facilities, or corporate businesses (i.e. pharmacy chains), our Webmaster can assist you to set up separate accounts for individual locations while still allowing administrators and corporate headquarter staff access to the information for all locations. Please indicate in your email to the Webmaster that you will be requesting multiple passwords for several Medi-Cal numbers and/or National Provider Identifier (NPI).

After you click on the icon, you will see the following screen:

![Windows Security dialog box](image)

After you have entered your Username and Password you will then be in the restricted area of the website.

All interactive features are listed along the left column of the page and are available for all provider types. The main page is the CenCal Health Data Forms Overview, and we encourage you to read this page the first time you access this area as it describes each of the options as well as the Data Entry Conventions you must use in the forms.
CHANGE PASSWORD

CenCal Health encourages our providers to keep this password secure and to change it whenever they have a change in staff. Once again, CenCal Health will not be held responsible for any erroneous use of a provider’s password. You must make every effort to secure it.

MEMBER IDENTIFICATION CARDS

Medi-Cal members receive a permanent plastic identification card called a Benefits Identification Card or "BIC". This card must be used for identification purposes but does not provide proof of eligibility. Providers must access eligibility information through one of the options made available by CenCal Health. These options include:

- SBHI and SLOHI's personal computer software program known as the Provider Network System (PNS)
- Direct contact with an CenCal Health eligibility representative

SBHI and SLOHI members will also receive a CenCal Health identification card. These cards are issued only once and reissued only when information on the card changes. These cards are intended only to be a means of identification; they are not to be considered proof of eligibility. Their major purpose is to indicate the member’s Primary Care Provider.
ELECTRONIC FUNDS TRANSFER

Electronic Fund Transfers (EFTs) are available through CenCal Health for various payment types. In order to receive EFTs, providers must enroll for the option to receive their payments electronically. It automatically credits any payments due for healthcare services performed directly to your savings or checking account. This payment method replaces issuing a paper check. Using EFT reduces paper processing and the errors associated with such processing. It also reduces costs related to check processing and postage and allows for faster response times to inquiries regarding the status of payments.

From this page, you will need to select Electronic Funds Transfer (EFT). Once selected, you will be able to choose from either EFT Enrollment or EFT FAQs. The FAQs contain helpful information about EFT and why it can be beneficial to your practice.

To continue enrolling in EFT, select EFT Enrollment and you will be brought to the screen below.
Please enter your Billing/NPI# as your Provider Number and click Submit. You will be brought to the screen shown below.

Information regarding the practice linked to the billing number you entered will automatically be entered in the Provider Information section. If you have payments going to an address other than the office's actual address, it will automatically populate under the heading Pay To. If no information is listed under Pay To, it means that the Actual address is also the payment address. The phone number associated with your office's actual location will also automatically populate in the Contact Information section.

A designated contact person will need to be chosen, and their name and email address will need to be entered in the Contact Information section. This person will receive all communication associated with EFTs. You can also change the phone number if there is an alternate number you would prefer to have on file.

The Bank Information section should be completed with the information for the bank account for which EFTs will be deposited. In addition to EOB payments, Primary Care Providers (PCPs) can enroll in EFT for Capitation and Incentive payments. Additional lines will appear under the Bank Information section for the additional payment types if applicable. Please see FAQs for more information on payment types that can be provided through EFT.

Once you enter the Routing #, the name of the bank associated with that routing number will automatically be filled in the Bank Name field. If the Bank Name does not fill in, please enter the name of your bank.

Bank Alias is the “nickname” that will identify the bank account that is being entered. If multiple accounts are being entered for various EFT types, these aliases can be helpful in identifying the various accounts.
The Account Holder field should be completed with the name of the individual or company for the account.

From the Account Type drop down, choose either Checking Account or Savings Account. The Account # should be completed with the number of the account that will receive EFT deposits.

To complete EFT Enrollment, please review the EFT Authorization Acknowledgement section and mark the box signifying that it has been reviewed. Click Submit and an email will be sent to the individual noted in the Contact Information section acknowledging that the enrollment process has been initiated. If you do not receive an email acknowledging enrollment within two (2) business days, please contact Provider Services at 805.562.1676.

If at any time you wish to cancel the enrollment process, please select the Cancel button at the bottom of the enrollment form.

Once a provider’s enrollment has been submitted through the website, the Provider Services Department will contact the authorized person at the practice to confirm the information submitted within two (2) business days.

Once confirmed, staff will initiate three (3) verification transactions: one deposit of $0.50 and two withdrawals totaling $0.50 to each bank account enrolled. The provider must then contact the Provider Services Department at (805) 562-1676 in order to confirm the two withdrawal amounts for each account. Once verified, the provider will be fully enrolled in the EFT program and begin receiving selected payments electronically.

Please Note: In order to track EFT transactions to bank statement(s) and/or to electronic remittance advice (835 files), providers will need to contact their financial institution and request that the Transaction Reassignment Number (TRN) be added to their statements for these transactions. This request should only need to be made once. Your first transfer could occur within ten (10) business days from the initial enrollment request.

CLAIMS ENTRY

There are four different types of claim forms that are supported on the Website: CMS-1500, UB-04, LTC, and LTC (Entry Only) Form. Below we will use the most common claim form type, the CMS-1500, for illustration.

Once you submit your claim you will receive a Claim Control Number (CCN). Every CCN is a unique identifier for each claim submitted to CenCal Health. The CCN consists of the date the claim is received (e.g. 20050309), the provider type (e.g. 02 is medical), the claim type (e.g. 88 is a Medi-Medi crossover claim), and a sequence number. For website submitted claims, the claim type is 09.
An example of a CCN appears below:

![CenCal Health CMS-1500 Form](image)

If you have questions once you have received the CCN, you may contact one of our Claims Customer Service Representatives at (805) 562-1083. Please have the CCN available so that the Claims Customer Service Representative will be able to immediately access the claim in our system and answer your questions.

1. To maneuver through the screen use your Tab key. Shift + Tab will allow you to move back one box. Click on the ‘Submit Form’ button to send the claim. Note: Your Enter key will reset the screen NOT submit the claim.

2. Dates are entered in the YYYYMMDD format (e.g. 20010321 for March 21, 2001).

3. Once the claim is completed, press the Submit Form button. Keep in mind your ‘Enter’ key will reset the form. After submitting, you will receive a message, “Your form was received successfully. Your Claim Control Number is YYYYMMDD0#9#####” as shown above.

4. You may then select Edit this Claim or Continue to a new Claim. If you select Edit this Claim, it will take you to the CenCal Health Claim Editor (see below). You will see a summary of the claim including the Explain Codes (Ex Codes). This is how the claim will appear on your next Explanation of Benefits (EOB).
5. If your claim is denied, you may make corrections to the claim by selecting **Modify this Claim**. Once you’re done making the corrections, press the **Edit Claim** button. Please be aware that some claims might be in a pended status and will be reviewed by CenCal staff.

6. You may edit the claim up to the time that it appears on the EOB. If you need to make corrections to a claim that already appeared on an EOB, you may do so by submitting a new claim along with the required correction online.

7. You may **not** use the **Back** button on your web browser to make changes. Instead, use the **Edit this Claim** button to edit the claim, and the claim will re-appear just as you submitted it, except that the CCN will appear in the top left corner of the claim.

8. When you are finished entering your claims, you may select the **Reports** option on the left side of the screen, and choose **Daily Claims**. After you enter the date the claim was entered, you will see a list of all the claims you have entered for that day. You may wish to print this for your records. On this Daily Claim Report, you will see for each claim line the CCN, Line Number, Provider Number, Member Number, Procedure Code used, any Modifiers, Quantity, Paid Amount, Payment Status, and Explain Codes.
You may also query and pull up any previously submitted claims by entering the CCN and pressing the **Query** button at the bottom of the claim screen. Remember, if the claim line has appeared on your EOB, you **cannot** make changes to the claim.

**UB-04 Form**

**LONG TERM CARE CLAIM SUBMISSION**

For Long Term Care claim submissions, there are two forms. Below you will find the information for each one. There are two separate forms for submitting website claims for Long Term Care (LTC). The first form, **LTC**, allows the provider to enter one claim line at a time. This allows the online adjudicator to review the claim and make a determination as to it being payable, deniable, or pended. If you use this form, you will be able to review each and every claim line immediately, and then make corrections.
The second form, **LTC (Entry Only)** has multiple claim lines, so the online adjudicator will not be able to review the claim and therefore you will **not** see the Claim Editor. Claims submitted this way can be reviewed and edited through the LTC entry form. On this form you must select the appropriate CenCal health program from the drop down box at the top of the form.

**ELIGIBILITY VERIFICATION**

After selecting **Eligibility** on the left hand column, choose the ‘Check Eligibility’ option. You will then see the following screen:

![CenCal Health Member Eligibility](image)

This screen only requires the following information:

1) The Member ID Number
2) The date of service for which you are verifying eligibility in the format YYYYMMDD

You may then hit **Enter** on your keyboard or click the **Submit Form** button. After you receive the response, you may print the screen for your records, and then select **Reset Form** to do the next eligibility verification.

This system only looks within CenCal Health’s member/subscriber database for the eligibility. There is a pass through capability to the State’s system if you click on the ‘Check with DHS’ button. Below is an example of the response from our system:

![CenCal Health Member Eligibility](image)
To verify eligibility for several Members the **Batch Eligibility** option can be found just below ‘Check Eligibility’. To create a new batch, simply click on the **New Batch** button. It will prompt you to name your batch.

After doing so, click on ‘Create a New Batch’, and it will take you to the following screen:

![CenCal Health Batch Member Eligibility](image)

After entering the Member ID and Date of Service (DOS) for each desired member, click on the **Check Eligibility** button. You will then see the eligibility of each member:

![CenCal Health Batch Member Eligibility](image)

On the left hand side there will be a series of buttons: red for an ineligible/unknown member; green for an eligible member; and yellow for a member who has a share of cost obligation prior to becoming eligible. You may then double click on the red, green, or yellow dot to bring up an individual eligibility screen that you may print for your files.

The examples below indicate a member who is eligible (left), and a member who is ineligible (right):

![CenCal Health Member Eligibility](image)
![CenCal Health Member Eligibility](image)
As you can see, with the ineligible member you may check their eligibility with the Department of Health Services. Doing so requires their date of birth, their BIC issue date, and the Provider’s PIN#.

**TRANSACTION SERVICES**

**SHARE OF COST**

Share of Cost (SOC) is a monthly dollar amount that a patient must pay or obligate to pay a provider for health care services before becoming eligible with Medi-Cal and SBHI & SLOHI. Once SOC is cleared, if the patient is a SBHI/SLOHI member, CenCal Health will pay claims over the SOC amount up to the allowable. The SOC determination is based on criteria supplied by the patient to his/her Eligibility Worker at the Department of Social Services. CenCal Health does not determine SOC or eligibility.

The screen located below is directly affiliated with DHS (Department of Health Services) when applying payment information. Also, when entering your ‘Prov#’ please submit your old Medi-Cal# as State does not recognize NPI#.

Once you press **Submit Form** you have cleared the transaction directly through DHS.
Note: It is the State, not CenCal Health that clears SOC. Although CenCal Health has the mechanisms to transmit this information to the State, no records are kept in our database. We strongly suggest that you print out the information if possible and place in the members record/file.

Note: Individuals within families may have varying SOCs. In these instances only the corresponding case number will need to be entered.

If for some reason an error has been entered, you will be able to make corrections by changing the Type to ‘Reversal’. If it has been cleared to $0.00 by mistake please document what happened in the member chart. Once a subscriber has been certified as having met the Share of Cost, reversal transactions may no longer be performed. Reversals may only be performed for partial clearance prior to the time the subscriber is certified as eligible.

MEDI-RESERVATION

A two service per month limitation applies to all Limited Service Providers. Limited Service Providers consist of Audiologists, Acupuncturists, and Chiropractors. Services applied to the two services per month limitation do not require a Referral Authorization Form (RAF) from the member’s PCP, but must be reserved through the Medi Reservation system below. A confirmation number will be given once the service is reserved. Please note: if a member needs additional audiology beyond the 2 service limit, additional authorization will be required. Members are restricted to a combined total of 2 acupuncture and chiropractic visits per month and will not be granted authorization for additional services beyond this limit.

The procedure code on the reservation must match the procedure code on the claim. If the code billed is different than the code reserved, reverse the reservation and resubmit it with the correct code. This can be done by selecting ‘Reversal’ in the drop down.

Note: Providers should not reserve a Medi-Service unless certain that the service will be rendered. Providers who do not provide a Medi-Service that has been reserved must reverse the reservation to allow the recipient to obtain another service.
AUTHORIZATION

There are currently four (4) Authorization forms available for submittal on the web. They are the TAR (50-1), Request for Extension of Stay in Hospital (18-1), LTC Authorization Form (20-1), and the Referral Authorization Form (RAF).

Simply fill out the appropriate form and click Submit. You will see a request number in the upper left corner of the form, which is your Authorization Request number. Please keep the TAR/RAF number available in your records.

TREATMENT AUTHORIZATION REQUEST (TAR) FORMS

Currently, the website e-TAR performs just like a blank paper TAR form. It will accept the form even if it contains mistakes. Some fields, like Provider# and Member# are required, and the form will not be accepted without them. If you have questions about submitting TARs, please contact the Utilization Management staff in our Health Services Department at (805) 562.1082.

1. To maneuver through the screen, use your Tab key. Your Enter key will submit the TAR to us. Shift + Tab will allow you to move back one box.

2. Dates are entered in the YYYYMMDD format (e.g. 20010321 for March 21, 2001).
3. For Medical TARs, you do not need to fill in the “U of Serv” field (Units of Service) or “Charge” field. However, you must complete the “Quan” field (Quantity).

4. Some fields in the form are automatically completed from data within our databases. For example, you need only to complete the field “Provider#”, and the Provider name will be populated by the name we have associated with that Provider Number within our network database. The same will happen for the Member name, sex, and birth date fields. However, if you input an invalid Member number, your e-TAR will still be accepted, but when the e-TAR number is assigned, you will see “Invalid ID#” in the Member Name field. Make sure you check the form after submitting it.

5. The section titled “Medical Justification/RAF#/Other Information” is a free form text field. You may type any information you wish to convey to our Utilization Management staff within this field. E-TARs submitted that require attachments and/or supporting documentation will be accepted, but you must submit the required information by FAX or through regular mail before the e-TAR can be reviewed. Please be sure to reference the e-TAR number obtained and the member name on all supporting documentation.

6. Once you have completed the e-TAR form, press the Submit button on the bottom of the screen. You will not get a return message, but a number will appear in the top left corner (e.g. W0000XX) of the form. This is the assigned e-TAR number. Note the number in the member’s chart or print a copy for your records. You are now ready to enter another e-TAR. Press the Reset Form button at the top or bottom of the form. Continue entering your e-TARs.

7. You may make changes to your e-TAR immediately if necessary. Enter the e-TAR number and press the Query button. You may edit the e-TAR up until our Utilization Management staff reviews it.

8. Once the Utilization Management staff has reviewed your e-TAR, you will receive an e-mail telling you the status of the e-TAR: Approved, Denied, Deferred, or “Other” status. You may then go back into the website, enter the e-TAR number, select Query, and review the Utilization Management staff member’s notes.

9. Once the Utilization Management staff has reviewed your e-TAR and it is approved or denied, you will not be able to edit the form. You must contact our Utilization Management staff if you need to make changes to the form after it has been approved or denied. However, if your e-TAR is deferred for more information or placed in “Other” status, you may do a query on the e-TAR number and edit the e-TAR. You may then resubmit it for review. Once again, you will receive an e-mail telling you the status.
You may review any previous e-TARs you have submitted in the past by querying on the e-TAR number. Also, as claims are submitted which reference the approved e-TAR, it will deduct one authorized service from the e-TAR under the field “Appr U” (Approved Units) and add one to the “U Used” (Units Used) field. In this way, providers may keep track of how many approved services or refills remain on the approved e-TAR.

NOTE: The number of ‘units used’ are counted each time a claim is received. If you have a claim that pends or is denied, do not resubmit, but rather make appropriate corrections on your Explanation of Benefits (EOB). When providers resubmit a claim, the unit is counted again. This creates a false reading on our e-TAR screens showing, in many cases, many more units used than approved.

REFERRAL AUTHORIZATION FORMS (RAFS)

The electronic Referral Authorization Form (eRAF) expedites the approval process and reduces administrative rejections that can cause the denial or delayed payment of claims. The e-RAF, unlike the e-TAR, will not be accepted if it contains mistakes. **The e-RAF does not guarantee payment or services to be rendered!** Always remember to contact the Referral Provider in question prior to sending a request.

Note: Some providers may not be set up to accept eRAF’s. In this case please contact the Provider Services at (805)562-1676 for assistance.

![CenCal Health Referral Authorization Form](image)
PCPs must complete the form in its entirety, including all relevant medical information, treatment orders, symptoms, and diagnosis codes. Remember to contact the Referral Provider to ensure they are accepting members of that program.

1. You should use the Tab key to navigate. Shift+Tab will move you back one box. Enter will submit the RAF to the Referral Provider.

2. The ‘From’ and ‘Thru’ dates must be entered in the YYYYMMDD format.

3. In the ‘Provider #’ box, your billing number should be entered. Please note that the RAF will be rejected if you submit a referral for member who is not assigned to your practice or is assigned to a PCP who you do not have an on-call relationship with.

4. Enter the Member’s ID in the ‘Member#’ box. The member’s name and information will auto-populate.

5. To select a referral provider, utilize the Lookup Specialist function. You may refine your search by selecting an area or specialty, or you may enter the provider’s last name, or by picking the specific specialty and press Lookup Specialist. Once selected from the list, the Referral Provider's billing number will auto-populate in the ‘Provider’ box. If the referral provider is not in the list of providers, please contact (805) 562.1676.

6. The ‘Reason for Referral’ box is mandatory and all fields within the box must be entered.

7. You may restrict services by selecting the ‘Limited to One Consultation/Office Visit’ box; otherwise, all medically necessary services within the Referral Provider's scope will be authorized. Note that the Referral Provider will need another RAF to provide services other than those specified.

8. Once all necessary fields are entered, press Submit. The ‘RAF#’ box will auto-populate with a number. The status of the RAF will reflect in the ‘Status’ box at the bottom of the form. If a RAF has been deferred, you will be notified within 5 business days of a decision.

9. CenCal Health will receive a copy of the RAF electronically and the Referral Provider will receive notice of the RAF and its status.
Referral Providers will receive an email notifying them a RAF has been submitted to their practice and the status of the RAF. You must verify the RAF has been approved and the dates of service fall within the designated date span prior to rendering services. As eligibility can change monthly, the Referral Provider must verify the member is eligible for any date of service.

You are allowed to refer for DME, lab work, radiology services, physical, occupational, and speech therapy, and services rendered in an outpatient hospital setting or surgery center. Authorization requirements will still apply for these services when applicable.

If the treatment required is beyond the timeframe or scope of care authorized by the RAF, please contact the PCP for another RAF.

Located below is a copy of an ‘Approved’ eRAF, please note that this is a sample and areas are blocked out due to HIPPA.
**AUTHORIZATION REPORT**

This allows a provider to see what and how many authorizations were submitted for a member, when it was submitted, and its status. To do a generic search, enter your Provider# and press **Submit Form**; you will then see all your members authorizations listed from most recent date.

*Note: CenCal Health must have a valid e-mail address to process Website submitted authorization requests as you will receive electronic status reports of your submitted requests via e-mail.*

**REPORTS**

There are 13 desktop reports that Providers may run themselves at any time. This section will describe each report and their capabilities.

**DAILY CLAIMS** – Please refer to the Claims Entry section of guide.

**CAPITATION** - This PCP monthly capitation report shows member aid codes, ages, and guaranteed payment amount per member per month. Below will reflect payment of summary per PCP practice. This report can be downloaded or printed by clicking on the icon.

**PCP MID-MONTH** – This report outlines a PCPs new or deleted assigned members per month. This reflects changes that are made prior to the middle of each month.

**CASE MANAGEMENT** – This report will show a PCPs Case Management List. You may query by plan on any month of any year.

**PATIENT PROFILE** – This report shows all services performed for a particular member during a specified time period by the provider. Enter a valid member ID number, program, from/thru dates, then click on **Submit Form** for a member claim report which shows all claims you have submitted on behalf of that member. To do another report, simply click on the **Reset Form** button.

**CLAIM STATUS** – Allows a provider to review all claims that have been submitted to date that are payable, deniable, or pending. You select which program you wish to run the report on and the provider number.

**CLAIM REPORT** – Allows a provider to review large volumes of claims at once. The maximum date span is 200 days. This report shows the same information as the Daily Claims Report but on a larger scale.
**EXPLAIN CODES** – This is a list of the Explain Codes which appear on the Claims Editor, Daily Claims Report, Patient and Provider Profiles, and EOBs.

**AUTHORIZATION REPORT** – This allows a provider to see all authorizations that were submitted for a member, when it was submitted, and its status. This report is also located under *Authorizations*.

**PCP 834 DOWNLOAD** - This is a HIPAA compliant Case Management file which generates an online report. Benefit Enrollment and Maintenance documents objective is to clarify what segments CenCal Health's 834 will contain, along with clarifying the definition of “generic fields” (i.e., group policy number). Please click on the ‘Download the SBRHA 834 Companion Guide’ for more information.

*Note: HIPAA is clear that member information that is sent in a file to a payer or provider must be in HIPAA format*

**SUBMITTER REPORT** – Displays a report of claims submitted through a clearinghouse by a provider and gives the claim status w/ link to edit minimal service line data and ability to reedit.

**ER REPORT** – This is an online tool for Primary Care Provider to assist in the care of their assigned members by monitoring ER usage.

**COORDINATION OF CARE** – This is an online tool for Primary Care Providers to review their practice and manage their members in a timely manner. Data on this form is pulled from existing claims.

**PROCEDURE PRICER**

CenCal Health hopes you find this reimbursement rate information for various procedure codes useful. The reimbursement rates are the latest in CenCal Health's database for contracted providers who do not have special contracts covering the procedure codes. The use of modifiers with the procedure codes will affect the reimbursement rates. In some cases, the member’s age and status can also influence the rate. In addition, CenCal Health reserves the right to retroactively or prospectively change the rates, and the rates may be affected retroactively or prospectively by State changes to the basic Medi-Cal rates.
After completing the necessary fields, click the button **Price It** or press the **Enter** key, and a price will appear in the field labeled **Allowable**, which is the current allowable for that particular procedure on that date of service. You may also receive messages like “not a benefit”, “modifier required”, or “manual pricing” in that field.

**IMPORTANT REMINDER**: Providers should **always** bill CenCal Health with their usual and customary charged amounts and not the allowable that appears on this screen or their EOBs. We are constantly changing and updating our data, including reimbursement rates, and you could short-change yourself.

**SMART PROGRAMS**

Successful **Management** **Always Requires a Team**. CenCal Health strives to enhance the scope of health care and services provided by our network of primary care physicians (PCPs) and specialists. Disease Management Programs are developed to provide education and targeted interventions to members with certain high-risk diseases. CenCal Health identifies members with certain chronic conditions and develops and implements network-based Disease Management Programs to address their health care needs. These programs work with PCPs and specialists to improve clinical outcomes, reduce or delay long-term complications, and manage the member's care in a cost-effective manner. Click [here](#) for the SMART Guide.

**CHANGE OF ADDRESS**

The purpose of this section is to notify us of any change in office staff, address, contacts, phone number, and any other information.

**PCP REASSIGNMENT REQUESTS**

On occasion, a Primary Care Physician (PCP) may encounter a situation that warrants a request to have a patient reassigned to a new PCP. CenCal Health has established a mechanism to address these issues. Please see the policy and procedure titled "PCP Request for Member Reassignment" in the PCP/Referral Provider Obligations section of the Provider Manual for detailed instructions. Outlined below is the procedure that should be followed when submitting a request via the website.

- Select "PCP Reassignment Requests" from the list of forms. Enter your provider ID# and the Member's Meds ID#. If the member is not currently eligible or is not assigned to you, you will receive an error message informing you of this.
- If the member is eligible and assigned to you, you will be taken to a different screen where you will choose the reason for your request from a drop-down list. All contractual and non-contractual reasons for requesting reassignment that meet CenCal Health's criteria are on this list.
You must enter supporting information in the "Provider Remarks" section, i.e. dates of member no shows, examples of how the member is non-compliant or abusive, etc. If left blank, the program will prompt you to enter your remarks.

When complete, click the "Submit" button on the form. Use the "Back" button to return to the previous screen to enter another request.

Requests will be approved if the documentation supports the request. If the documentation submitted was unclear or insufficient, the Provider Services QI Manager will contact the provider for clarification prior to reaching a decision. Requests submitted after the 10th of one month through the 10th of the next month are processed by the cut-off date (10th day of each month). PCPs may return to the website after the request has been processed to verify approval and the effective date by using the "Query" button on the PCP Reassignment Request form.

The member’s new assignment becomes effective the first day of the following month. The PCP who requested the reassignment continues to be responsible for the member’s care until the new assignment is in effect.

If you do not have Internet access, please call Provider Services at (805) 562.1677 for further instructions.
**Formulary Addition/Deletion Request Form** - This form is to be completed by our Providers when requesting that a medication be added or deleted from the formulary. Will only consider this form if completed by a Physician.

**Medical Request Form (MRF)** - For medications that state “PA required” and those medications not on CenCal Health's Drug Formulary, MRFs may be available for members through the prescribers’ completion and approval of a Medical Request Form.

Prescriptions for the following require a MRF:
- All non-formulary medications,
- Brand name drugs when an equivalent generic is available except for those drugs listed as exemptions,
- Drugs not meeting the Code 1 restriction or Step Therapy criteria,
- and/or Drugs exceeding the member age, dosing limit, quantity or duration of treatment dispensing limits.


**HCPC Codes Requiring Specialty Fulfillment** - List of HCPC codes for Medical Providers that must be obtained through the Specialty Pharmacies, Diplomat and Accredo. All medications on this form require a Medical Request Authorization Form (MRF).

**Synagis Medication Request Form** - This specific medication request form is mandatory for all Synagis prescriptions.

**Hepatitis C Medication Request Form** - This specific medication request form is mandatory for the authorization of Hepatitis C Anti-Viral Therapies.
The Radiology Benefit Manager (RBM) process enhances the quality of services delivered to patients and reduces unnecessary radiation associated with advanced diagnostic imaging.

CenCal Health has been focusing on provider consultations and patient safety as a means to control for appropriate utilization of high-tech imaging. CenCal Health selected Care to Care, a URAC accredited as our new partner effective June 1, 2015. The goal is to improving our Radiology Benefit Management (RBM) program for high-tech imaging to enhance the quality of services delivered to patients and reduce unnecessary radiation associated with advanced diagnostic imaging.

**Applicable Services**

This program applies to the following outpatient services:

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

The ordering physician's office must contact Care to Care to request an authorization prior to ordering a high-tech imaging service. Based on clinical information from the physician's office, Care to Care will then make consultative determinations using the clinical guidelines published on their website.

Requests can be submitted via phone, fax or through Care to Care's Care Portal [www.cencal.careportal.com](http://www.cencal.careportal.com)

*(Authorizations are valid for 90 days from the date of the consultation)*

**Expectations**

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, urgent care centers, or intra-operative procedures are excluded from the high-tech imaging consultation requirement. Imaging studies for members who have other health care coverage are excluded from the consultation process requirement.
Required Information

<table>
<thead>
<tr>
<th>What information is required when requesting prior authorization?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Member (Patient) Name, Member DOB, Member ID number and ordering Physician Name and Address</td>
</tr>
<tr>
<td>• Name of Facility where services will be performed</td>
</tr>
<tr>
<td>• Radiological or Imaging Procedure to be performed</td>
</tr>
<tr>
<td>• Medical Indication(s) for requested procedure and ICD-9 code as available. Be sure to include:</td>
</tr>
<tr>
<td>• Member’s major complaint</td>
</tr>
<tr>
<td>• What the referring physician is looking to rule out</td>
</tr>
<tr>
<td>• Results of any lab findings, prior tests or imaging procedures</td>
</tr>
<tr>
<td>• Outcome any prior treatment, including type and duration, for the same medical indication</td>
</tr>
</tbody>
</table>

Consultation requests can be made to Care to Care via phone, fax or web:

Phone: 1 (888) 318-0276
Fax: 1 (888) 717-9660
Web: www.cencal.careportal.com

Care to Care’s call center is open: M-F 5am – 5pm PST.