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BEHAVIORAL HEALTH THERAPY (BHT) SERVICES

On July 7, 2014 the Centers for Medicare and Medicaid Services (CMS) clarified that Behavioral Health Therapy (BHT) services should be a benefit of the Medi-Cal Program for children 0-21 years of age with Autism Spectrum Disorder. The California Department of Health Care Services plans to provide funding for CenCal Health to cover these services to members who qualify and are not already receiving treatment through Tri-Counties Regional Center (TCRC). Services to those members already in treatment with TCRC will continue while a transition is being developed.

CenCal Health welcomes the opportunity to improve the health and wellbeing of children with Autism Spectrum Disorder and their families. Please take a moment to review the criteria below regarding how these important health benefits can be accessed by your patients. Also, please watch for an invitation to our upcoming seminar to learn more.

New Behavioral Health Therapy (BHT) Benefit

In order to be eligible for services, a CenCal Health member must meet all of the following coverage criteria.

The child must:
• be 0 to 21 years of age and have a diagnosis of ASD;
• exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to, aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);
• be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID);
• have a comprehensive diagnostic evaluation (2) that indicates evidence-based BHT services are medically necessary and recognized as therapeutically appropriate; and
• have a prescription for BHT services ordered by a licensed physician or surgeon or developed by a licensed psychologist. At this time, the State has not defined limits on the number of visits a member can have with a licensed health professional. Benefits will be arranged through The Holman Group and provided based upon medical necessity and the level of care needed to make progress towards treatment goals.

Accessing Services

TCRC will continue to provide care to those members already in treatment and BHT services will be arranged for and provided through The Holman Group’s provider network. Primary Care Providers (PCP) may refer members for BHT services by accessing

The Holman Group
24 hours a day, 365 days a year via their toll-free number 800.321.2843. The Holman Group will conduct an initial screening and arrange for the member to have a face-to-face assessment with a licensed professional or refer to another appropriate resource.

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BHT service providers interested in offering these services to members can join the Holman Group network. To request a contract and credentialing application directly from The Holman Group, please contact Liz Santillan in Provider Relations at 800.321.2843 extension 258 or visit their website at www.holmangroup.com.

Next Steps
CenCal Health will be providing a seminar on the new benefit for Autism Spectrum Disorder soon and representatives from the Holman Group, TCRC and your local County Mental Health Department will be in attendance. As aspects of this new benefit are defined, CenCal Health will provide additional information.

If you have questions or to arrange for an on-site visit at your office to discuss this new benefit and how you can assist your patients in accessing services, please feel free to contact your CenCal Health Provider Services Representative at 805.562.1676.

REFERRAL AUTHORIZATION FORM TIP SHEET
Referral Authorization Forms (RAFs) allow PCPs to refer their assigned members to specialists and allied providers for medically necessary services. To ensure RAFs are processed quickly and not rejected, we have listed a few frequently asked questions below:

Q. Do members with an assigned PCP of ‘CenCal Health’ require a RAF?
A. No. These Members are considered special class and are assigned to CenCal Health until they have selected and/or been assigned to a PCP.

Q. Do California Children Services (CCS) members require RAFs from CenCal Health?
A. No. Although CCS members are assigned to PCPs, they do not require RAFs. If a service is related to the member’s CCS condition, a provider must obtain an authorization from CCS called a Service Authorization Request (SAR). If a service is not related to the member’s CCS condition, a RAF is still not required. CenCal Health, however, retains the right to redirect a service to a contracted provider within our Service Area if the service is not related to the member’s CCS condition.

Q. Do members with other health care coverage require RAFs from CenCal Health? (Continued)
A. No. Members with dual health care coverage do not require RAFs even if the service is not covered by their primary health insurance plan. This includes members with Medicare. If a member’s only other coverage is a vision or prescription plan, then a RAF is required for medical services.

Directions and guidelines on obtaining and submitting RAFs can be found in the Provider Manual located on CenCal Health’s website, www.cencalhealth.org. Please contact your Provider Services Representative at 805.562.1676 for questions or training on the referral process.

CLAIMS CORNER
2015 CPT-4 AND HCPCS CODES NOT YET ADOPTED FOR MEDI-CAL
As a reminder, Providers should not use the new 2015 CPT or HCPCS codes to bill CenCal Health’s Medi-Cal program until further notice. The effective date for use of these codes will be published later in the year.

The 2015 updates (new codes, code changes and deletions) became effective for our AIM (PP2) and Healthy Kid’s programs as of January 1, 2015.

NEW NCCI MODIFIERS
Four new modifiers have been established for dates of service on and after January 1, 2015 that describe clinical situations currently indicated by modifier 59 (“Distinct Procedural Service”). They are as follows:

XE - Separate encounter: a service that is distinct because it occurred during a separate encounter
XP - Separate practitioner: a service that is distinct because it was performed by a different practitioner
XS - Separate structure: a service that is distinct because it was performed on a separate organ/structure
XU - Unusual non-overlapping service: the use of a service that is distinct because it does not overlap usual components of the main service

Modifier 59 is often misused to bypass procedure-to-procedure (PTP) edits because it is non-specific in its description. These four new modifiers were established so that providers could specify more clearly the situations in which PTP edits are eligible to be bypassed.

Please note that modifier 59 will remain a valid PTP-associated modifier. However, providers should use one of the new modifiers, instead of modifier 59, if the clinical situation described by one of the new modifiers applies to the particular coding situation.

The Provider Bulletin is produced as a timely supplemental information service for provider office staff and is published monthly by the Provider Services Department. Questions and/or suggestions for articles may be made to psrgroup@cencalhealth.org or by calling 805.562.1676. Sign up for the electronic Provider Bulletin at http://www.cencalhealth.org/for_providers/bulletins/index.html