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Case Management Services – It’s A Collaborative Process!

CenCal Health now offers Case Management (CM) Services, a shared process of assessment, care coordination, and advocacy for options and services that meet the needs of our members.

Our Case Management Services help members who:
- Have complex medical or behavioral health conditions.
- Have high psychosocial risk factors.
- Need assistance navigating through the health care system and continuum of care.

If you have a member that needs assistance, please refer them to our Case Management Services by submitting a Case Management Referral Form found on our website http://www.cencalhealth.org/providers/case-management/ and calling CenCal Health at (805) 692-5140.

Upon referral, a Case Manager will screen for appropriateness and triage for the urgency of initiating CM services. If the member accepts assistance, the Case Manager will formulate a Plan of Care and inform the member’s PCP. If the member declines assistance, the Case Manager will notify the referral source.

When a Member Should Be Referred to Case Management Services:
- Frequent emergency department use, hospital admissions or readmissions within 30 days of discharge.
- Members who need education on their chronic medical condition and/or medication adherence.
- Unstable medical conditions warranting closer monitoring (e.g. CHF, diabetes, exacerbating asthma or COPD).
- Assistance with coordination to community resources (e.g. Food Bank, Meals on Wheels, Family Resource Centers, and/or Unity Shop).
- Receiving medically necessary services within or outside the CenCal Health provider network.
- Complex medical condition, including those affecting multiple organ systems or complicated therapy (e.g. transplants, cancer, ESRD, terminal illness without hospice services).
- Members with fragile conditions, including cognitive changes needing assistance with care coordination or care transitions.

For more information on this service, please contact the Health Services Department at (805) 562-1082 or reference our website at: http://www.cencalhealth.org/providers/case-management/
Transition from InterQual Guidelines to Milliman Care Guidelines

When determining covered services, benefit limitations, and medical necessity CenCal Health uses Medi-Cal guidelines as the primary source. When Medi-Cal guidelines are not available or not applicable, CenCal Health uses InterQual Guidelines as the primary determinant of medical necessity. To provide better quality, CenCal Health will be transitioning from the current InterQual guidelines to Milliman Care Guidelines (MCG) on June 1, 2016. MCG guidelines will also be used during the review process for acute inpatient and transitional care stays.

For further information, please contact our Health Services Department at (805) 562-1082.

Reminder: Prescribing Oxygen Therapy

A reminder to providers that all oxygen qualification testing must be performed in-person by a physician or other medical professionals qualified to conduct oximetry testing. Oxygen suppliers, such as a DME vendor, are not considered a qualified provider or a qualified laboratory for purposes of this procedure.

**Before ordering oxygen therapy, prescribing providers must:**
- Ensure that an oxygen qualification test is performed within 30 days of the request (or no more than 2 days prior to hospital discharge) when members must be in a chronic stable state.
- The medical need and goal of therapy is determined.
- Evaluation of the member for hypoventilation syndromes has been completed (i.e. CPAP for sleep apnea).

**When prescribing for oxygen therapy, please include the following documentation:**
- Oxygen flow chart
- Frequency requirements
- Duration of use

Please visit: http://files.medi-cal.ca.gov/pubsdoco/Bulletins_menu.asp for additional information regarding the use of Oxygen Therapy.

For any additional questions, please contact our Health Services department at (805) 562-1082.

On The Horizon: CHDP Claims Payment Carve-In Training

Effective July 1, 2016, CenCal Health will begin administering payment for all CHDP services. A vendor will be assisting with the processing of these services and PM 160 data by offering an efficient and user-friendly online solution. CenCal Health will be hosting a free informative CHDP Claims Payment Carve-In Training in June of 2016 with invitations to be mailed out soon.

For additional questions, please call your Provider Services Representative, or email: psrgroup@cencalhealth.org


3 Ways to Submit a Claim

CenCal Health makes it easy for you to submit a claim. We have three ways to do so and it is faster, easier, and direct!

1. **Electronic:** To find out more about submitting claims electronically to CenCal Health, contact AdminISTEP by phone at (888) 751-3271 ext. 3141 or on the website at www.administep.com

2. **CenCal Health Website:** CenCal Health has implemented electronic billing through our web portal. It is fast and easy. You can edit claims at the time of entry to assure claims are clean and ready for payment. Visit our Provider Portal to get started.

3. **Paper Forms:** Still using paper? Listed below is the mailing address for paper claims.

   **Send original claims to:**
   CenCal Health
   PO Box 948
   Goleta, CA 93116-0948

   For questions, please call our Claims department.

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/providers/provider-bulletin/.
CDC’s *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

### Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

### Clinical Reminders
- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

[Learn More](www.cdc.gov/drugoverdose/prescribing/guideline.html)
When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

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