



*Improving the health and well-being
of people on the Central Coast*



Pharmacy Provider Manual

Revised: March 2020



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Section A: Introduction

A1: GENERAL INFORMATION

Welcome to the CenCal Health Plan Pharmacy Manual

CenCal Health is a County Organized Health System (COHS) that administers the Medi-Cal program in Santa Barbara and San Luis Obispo Counties. We have been in operation since 1983, and are recognized nationally as the oldest Medicaid managed care program of its kind in the country. We contract with the State of California to administer Medi-Cal benefits through local health care providers in Santa Barbara and San Luis Obispo counties. We presently have over 275 Primary care physicians and 1250 specialists that provide care to our members. They give generously of their time and expertise. We also have a very dedicated board of directors that come from within our community. They donate their time to oversee and ensure the best outcome for our members, and oversee our budget. All programs are case managed by Primary Care Physicians (PCPs) of the member's choosing or by plan assignment. The following are current programs CenCal Health administers:

- **Santa Barbara Health Initiative (SBHI)** is the first case managed Medi-Cal program in the State of California. Our program has been widely viewed as a model for other counties and states.
- **San Luis Obispo Health Initiative (SLOHI)** is CenCal Health's program for Medi-Cal recipients in San Luis Obispo County.
- Both counties are known as a local community health plan, of varying ages, categories of aid, and medical conditions and our main program is Medi-Cal.

CenCal Health is pleased to provide you with this Pharmacy Manual. Although CenCal Health is responsible for pharmacy management policy and overall program administration, CenCal Health has contracted with a pharmacy benefit manager, MedImpact, to assist in the administration of its pharmacy program. CenCal Health shall oversee MedImpact's role in assisting the pharmacy network with claims processing and day-to-day operations.

This CenCal Health Pharmacy Manual is a comprehensive tool outlined to address common inquiries regarding CenCal Health's Pharmacy Benefit. CenCal Health welcomes any suggestions related to this manual. Communication related to suggestions for improvement should be directed to the CenCal Health Pharmacy Services Department at (800) 421-2560 extension 1080 or (805) 562-1080.

This Pharmacy Manual will assist you in:

- Providing optimal pharmaceutical services to CenCal Health members consistent with CenCal Health policies and procedures
- Provide you with administrative guidelines and detailed procedures to be followed to ensure that CenCal Health's member receive pharmaceutical services consistent with the CenCal Health scope of benefits
- Provide you with pertinent information that is necessary to achieve our mutual goal of providing quality pharmaceutical services to CenCal Health members

The CenCal Health Pharmacy Manual contains useful information on the following topics:

- Member Eligibility
- Covered Services
- Drug Formulary
- Medical Request Form (MRF) Process
- Claims Submission
- Coordination of Benefits (COB)
- Provider Grievance Process
- Pharmacy Audits

Organization of the Pharmacy Provider Manual

This Pharmacy Provider Manual describes the operational policies and procedures of CenCal Health. The covered topics are included in the Table of Contents at the beginning of the Provider Manual. You may also access the Provider Manual online by visiting CenCal Health's website at: www.cencalhealth.org. The manual will be updated and revised periodically as needed to reflect ongoing changes.

A2: Participating Pharmacy Network

All DHCS enrolled participating pharmacies provide pharmacy services for eligible members of CenCal Health and are contracted with MedImpact:

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Ct.
San Diego, CA 92131
Telephone: 1-800-788-2949
www.medimpact.com

A3: Pharmacy Reimbursement

Participating network pharmacies receive reimbursement from MedImpact for pharmacy services provided as specified for a covered medication and/or reimbursable service as identified in the MedImpact Pharmacy Network Agreement Plan Sheet. MedImpact reimbursement is based on the lower of:

- Average Wholesale Price (AWP) less the contracted discount plus the contracted dispensing fee, or
- Maximum Allowable Cost (MAC) plus the contracted dispensing fee, or
- Usual & Customary (U&C), or
- Submitted Price

Pharmacies are paid on a bimonthly reimbursement schedule as follows: Claims filled from the 1st through the 15th of the month are paid on the 25th of that month. Claims filled from the 16th through the 31st of the month are paid on the 10th of the following month.

A4: Pharmacy & Therapeutics (P&T) Committee

The Pharmacy & Therapeutics (P&T) Committee meets quarterly, or as needed, to provide proper guidance for the development, implementation, and maintenance of the CenCal Health Drug Formulary. The P&T Committee is responsible for making recommendations to CenCal Health regarding the content of the CenCal Health Drug Formulary and other clinical matters regarding the CenCal Health drug benefit. The Committee's membership is comprised of the CenCal Health Chief Medical Officer or their physician designee, the CenCal Health Director of Pharmacy Services, plan pharmacists, network physicians, network pharmacists, and other health care professionals from the community. Community practitioners interested in becoming a P&T Committee member may contact CenCal Health's Pharmacy Services Department at (805) 562-1080.

A5: Drug Formulary

The CenCal Health Drug Formulary is a listing of medications approved and covered by CenCal Health. This is a “living” document and will change according to the latest developments in clinical, evidence-based literature. CenCal Health’s Drug Formulary is available on CenCal Health’s website in a PDF or web-searchable version at:

<https://www.cencalhealth.org/providers/pharmacy/>

A6: Scope of Prescription Drug Benefit Coverage

The scope of CenCal Health’s prescription drug benefit includes all Food & Drug Administration (FDA) approved legend and non-legend medications that are on the CenCal Health Drug Formulary. Those medications not on CenCal Health’s Drug Formulary may be available to members through the completion and approval of a Medical Request Form (MRF). Please refer to the Medical Request Form (MRF) Process section of this manual for more information.

A7: Reporting Fraud, Waste and Abuse

CenCal Health takes reports of fraud, waste and abuse very seriously. All providers are required to report incidents of fraud, waste and abuse to CenCal Health within ten (10) days from the date when you first became aware or were put on notice of such activity. If you suspect another provider of fraudulent activity such as up-coding or performing unnecessary services, please report this information to the plan. Please also report any CenCal Health member you suspect may be committing fraud.

Healthcare Fraud, Waste and Abuse are defined as follows:

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (Title 42 CR 455.2; Welfare and Institutions Code 1403.1 (i))

Waste: Over utilization of services (not caused by criminally negligent actions) and the misuse of resources

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement of services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the

Medicaid program. (Title 42 CR 455.2 and as further defined in Welfare and Institutions Code 14043.1(a))

When reporting fraud, waste or abuse, please provide as much of the following information as possible:

- Name of person or persons suspected of committing fraud, waste or abuse (first name, last name)
- Identifying information such as provider/member name, address telephone number
- Description and details of the suspected fraud, waste or abuse: who, what, where, when, date and time of incident(s)
- Any documentation you may have which is related to the situation
- Your name, telephone number and address (if you would like to be contacted)

To report fraud, waste or abuse to CenCal Health, please call the toll free 24-hour Fraud Hotline at (866) 775-3944. Callers may identify themselves or remain anonymous.

To report in writing, please complete the *Suspected Fraud, Waste or Abuse Form* located in the Providers section of the website at: www.cencalhealth.org

The form should be mailed to the following address:

CenCal Health
Attn: Fraud Investigations-Compliance
4050 Calle Real
Santa Barbara, CA 93110

A8: USEFUL TELEPHONE AND FACSIMILE NUMBERS

Contact Information	Phone Numbers
Member Services	(877) 814-1861
Provider Services	(805) 562-1676 (Santa Barbara County) (805) 541-7095 (San Luis Obispo County) (800) 421-2560 ext. 1676 Email: providerservices@cencalhealth.org
Claims Department	(805) 562-1083 (800) 421-2560 ext. 1083 Email: cencalclaims@cencalhealth.org
Health Services	(805) 562-1082 (800) 421-2560 ext. 1082 (877) 931-2227 Radiology Benefit Manager (Care to Care) Pediatric Unit (805) 562-1082 Option 1 Adult Case Management (805) 562-1082 Option 3 Quality Measurement & Improvement (805) 617-1997 Email: qualityimprovement@cencalhealth.org
Pharmacy Services	(805) 562-1080 (800) 421-2560 ext. 1080 (800) 788-2949-Med-Impact
Video & Telephonic Interpreter Services	(800) 225-5254-Over the Phone Operator Customer Code: 48CEN

	Email: certifiedlanguages.com (877) 814-1861 - Sign Language
Finance-Recoveries Unit	(805) 562-1081 (800) 421-2560 ext. 1081
Fraud, Waste & Abuse Reporting	(866) 775-3944 Mail: CenCal Health Attn: Fraud Investigations – Compliance Coordinator 4050 Calle Real, Santa Barbara, CA 93110

Section B: Member Eligibility

CenCal Health receives member eligibility for its members from the State of California, and it is then forwarded to MedImpact for inclusion into their online eligibility system.

B1: Eligibility Verification

Each CenCal Health member should present either a SBHI or SLOHI (Medi-Cal), Healthcare Identification Card at the time a have a prescription filled. Members should also present their State Benefits Identification Card (BIC).

The Identification Card contains the member’s name, birth date, and identification number. The identification number (ID) is the member number used when submitting claims to MedImpact. We have provided a sample of CenCal Health’s Identification Card at the end of this section. In the unlikely incidence that MedImpact rejects a prescription claim for “Non-Matched Cardholder ID,” any one of the following procedures may verify eligibility:

- by calling the CenCal Health Member Services Department at (877) 814-1861 or (805) 562-1001, Monday through Friday, 8:00 a.m. to 5:00 p.m.
- by calling the State Automated Eligibility Verification System (AEVS) at (800) 456-2387.

B2: CenCal Health Member ID Cards

All members under CenCal Health will have the following version of their member identification card.

All CenCal Health members are to utilize the same BIN, Carrier or Processor Control Number (PCN), and Group numbers as indicated below:

Pharmacy BIN: 003585
Carrier or PCN: ASPROD1
Group #: CEN



B3: Newborns

SBHI and SLOHI newborns are eligible for pharmacy benefits the month of birth and the ensuing month under the mother's eligibility and ID number. If information on the newborn is not found in CenCal Health's eligibility system, you may call CenCal Health at (877) 814-1861 or (805) 562-1001 or the Pharmacy Department at (805) 685-9525 at extension 1080, Monday through Friday, 8:00 a.m. to 5:00 p.m. PST. Please refer to the Claims Submission section of this manual for billing instructions.

B4: Share of Cost (SOC)

Some SBHI and SLOHI members must meet a specified Share of Cost (SOC) for medical expenses, including prescriptions, before they can be eligible to receive Medi-Cal benefits within a given month. SOC dollar amounts can be verified through AEVS or www.cencalhealth.org. Providers may also clear a SOC by contacting the State of California at (916) 636-1000 or (916) 636-1200 or via the plan's website, www.cencalhealth.org. All health services including medical services, devices, and prescription drugs, whether Medi-Cal covered or not, can be used to meet SOC. Pharmacies must clear SOC transactions at the time services are rendered. Once the member has met his/her SOC obligation for a given month and becomes Medi-Cal, eligible, future prescriptions for that month may be billed to MedImpact.

B5: Restricted Services

A CenCal Health member may be placed on a restricted status for receiving prescription medications prescribed in an outpatient setting based on determination by CenCal Health that the member has used such services inappropriately. If members are determined to have potentially inappropriate prescription medication usage, they may be subjected to the following restricted status:

- Prior Authorization using a Medical Request Form (MRF) required for all medications,
- Prior Authorization using a MRF required for controlled medications, and/or
- Allowed to use only one specific pharmacy chosen by the member.

Providers may request that a CenCal Health member be reviewed for potential restricted status by contacting the CenCal Health Pharmacy Services Department at (800) 421-2560 extension 1080 or (805) 562-1080.

B6: Whole Child Model (WCM) and California Children Services (CCS)

CenCal Health administers the Whole Child Model (WCM) for the California Children's Services (CCS) Program for all eligible members in Santa Barbara and San Luis Obispo Counties. The WCM will provide comprehensive coordinated services for children and youth with special health care needs. The focus is on the whole-child, including the child's full range of needs as well as their CCS condition.

CenCal Health will be responsible for payment, authorizations and care coordination of services for CenCal Health CCS eligible members. Eligibility will continue to be determined by Santa Barbara and San Luis Obispo County CCS Departments.

California Children Services (CCS) is a program that provides specialized medical care and rehabilitation for physically disabled children up to twenty-one (21) years of age whose families are unable to provide for such services. The necessary specialists established the CCS program to ensure that children with physically disabling conditions receive quality health care for their eligible conditions at the appropriate time and place. Referrals and questions to the CCS program may be directed to the local Santa Barbara office at (805) 681-5360 or to the local San Luis Obispo office at (805) 781-5527.

B7: Genetically Handicapped Persons Program (GHPP)

Genetically Handicapped Persons Program (GHPP) is a State funded program that coordinates care of persons over twenty-one (21) years of age with the following conditions:

- Hemophilia and other hereditary bleeding conditions
- Cystic Fibrosis
- Sickle Cell Disease and Thalassemia
- Huntington's Disease, Friedreich's Ataxia, and Joseph's Disease
- Selected hereditary metabolic disorders including Phenylketonuria (PKU)
- Von Hippel Lindau Disease

All authorizations and payments are the responsibility of GHPP and EDS. Referrals and questions about the program may be directed to the GHPP program at (916) 327-0470 or (800) 639-0597.

B8: Medicare

Medicare's outpatient prescription coverage is currently limited to selected drugs. When a member is eligible for both Medicare Part B and SBHI Medi-Cal or SLOHI Medi-Cal, the pharmacy provider must bill Medicare as the primary insurer and CenCal Health as the secondary insurer. Please refer to the Coordination of Benefits (COB) section in this manual under Medicare COB for billing instructions.

Dual-eligible members (those individuals who have both Medicare and Medi-Cal coverage), will have their Medi-Cal covered drugs provided through the Medicare Part D Program and the Prescription Drug Plan (PDP). CenCal Health is not responsible for the outpatient drug benefit of dual-eligible members as mandated by the federal government. CenCal Health will however, continue to cover a minimal amount of therapeutic drugs. All communications regarding the PDP's policies, formulary, and prior authorizations should be directed to the PDP itself or to Medicare via 1-800-Medicare.

Section C: Covered Services

This section of the CenCal Health Pharmacy Manual contains an overview of prescription benefits provided to CenCal Health members, as well as specific guidelines for the pharmacy provider when providing prescription services to CenCal Health members. Information regarding claim submission through MedImpact's online prescription claims processing system or for claims billed directly to CenCal Health is provided in the Claims Submission section of this manual. Additional information regarding the

Medical Request Form (MRF) can be found in the section titled Medical Request Form (MRF) Process.

C1: Prescription Drugs

CenCal Health's prescription drug formulary contains selected Federal Legend Drugs from all the major therapeutic drug classes. The drugs are listed in the drug formulary by both the generic and/or brand name. The "Brand" names listed are for reference use only and do not denote coverage. The Formulary can be found at: www.cencalhealth.org.

C2: Dual Eligible Members Prescription Drug Coverage

The provision of the drug benefit for our dual-eligible members (those individuals who have both Medicare and Medi-Cal coverage) has shifted from CenCal Health to a Medicare D provider. If the member has Medicare Part D coverage, the pharmacy must submit claims for Medicare-covered drugs/supplies to the Medicare carrier as the primary insurance. The following medications/classes of drugs will continue to be covered for dual-eligible members as long as the regular processes (i.e. step edits, quantity restrictions, prior authorization, etc.) are followed:

1. Medications related to anorexia, weight loss or weight gain;
2. Medications for symptomatic relief of cough and colds;
3. Some non-prescription medication, such as OTC's including formulary medical supplies; and OTC tobacco cessation products
4. Prescription vitamins and minerals on CenCal Health's Formulary

C3: Specialty Pharmacy Coverage

CenCal Health provides comprehensive specialty pharmacy services through our exclusive relationship with Diplomat Specialty Pharmacy. This exclusive agreement allows CenCal Health members to receive clinical assessments, patient education, and management of patient adherence to therapy by Diplomat Pharmacy.

The specialty pharmacy will provide CenCal Health members with high cost medications that treat chronic and complex diseases with a comprehensive approach in medication management. All Specialty Medications require a Medical Request Form (MRF).

For a complete list of Specialty Medications, please visit the CenCal Health Website:

<https://www.cencalhealth.org/providers/pharmacy/specialty-pharmacy/>

If you have any questions regarding this program under CenCal Health's pharmacy benefit, please contact the Pharmacy Department at (800) 421-2560, extension 1080 or contact Diplomat directly at (877) 319-6337.

C4: Over the Counter (OTC) Drugs

Selected over-the-counter (OTC) drugs are a part of the SBHI and SLOHI benefit if prescribed by a licensed provider/prescriber. Providers cannot separately bill for any OTC drugs for members residing in a nursing facility, as OTC drugs are included in the per-diem rate. OTC drugs are listed in the Formulary, which is available online at www.cencalhealth.org

C5: CenCal Health-DME & Medical Supplies

Pharmacy claims for the medical supplies and DME prescriptions listed below must be billed to CenCal Health's Pharmacy Benefit Manager (PBM)

Pharmacy Benefit Medical Supply/DME Items

- Blood Glucose Monitor
 - -Freestyle Lite
 - -Freestyle Freedom Lite
 - Freestyle InsuLinx
 - Precision Xtra
- Lancet and Lancet Devices
- Insulin Syringes
- Peak Flow Meters
- Pill Cutters
- Inhaler Assisted Devices (Spacers)
- Blood Glucose Strips
 - Freestyle Lite
 - Freestyle Freedom Lite
 - Freestyle InsuLinx
 - Precision Xtra
- Injection Supplies other than Insulin Syringes
- Disposable Syringes
 - Disposable Needles
 - Disposable Syringe w/Needle

- Pen Needles
- All other DME and medical supplies must be billed directly to the CenCal Health Claims Department. Only contracted CenCal Health DME providers will be allowed to bill the Claims Department directly. Additional information for the billing of DME and medical supplies can be found in the CenCal Health provider manual at: www.cencalhealth.org/provider/forms-manuals-policies/provider-manual.

C6: CenCal Health-Dual Eligible Members/DME & Medical Supplies

If a member has Medicare Part B &/or D, the provider must bill Medicare as the primary insurer for Part B or D covered medical supplies and DME items. CenCal Health may be billed for a 20% Part B copay or deductible, after the Part B carrier claim has adjudicated and the member's deductible &/or copay has been determined. CenCal Health does not reimburse part D copays.

State law mandates Medi-Cal to be the payer of last resort, and requires the utilization of other available health care coverage prior to the utilization of Medi-Cal. Other coverage is always the primary payer and cannot be waived by the member. Please bill the members other coverage first prior to billing CenCal Health.

Section D: Prescription Limitations

D1: SBHI/SLOHI Prescription Benefit-Polypharmacy

In our continuing efforts to improve patient safety and quality of care, CenCal Health has implemented a Polypharmacy Management Quality Initiative for Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) members. The scope of pharmacy benefits for SBHI and SLOHI members will include a maximum benefit of seven (7) prescriptions per calendar month. The following disease states and categories are exempt from this restriction:

- Immune System Suppression Medications/Modulation Medications
- Infectious Disease Treatment Medications
- Immunization Vaccines
- Family Planning Medications
- Cancer Treatment Medications
- Diabetes Treatment Medications
- Asthma and COPD, Hypertension Treatment Medications
- Long Term Care Members, or
- Newborn using Mom's card

Please remember: All drugs exempt from the monthly prescription limit are still subject to all other CenCal Health guidelines.

If the member does not meet any of the above criteria and their physician has consolidated the member's profile, the physician may request a **Pharmacy Authorization Form (PAF)**. This form, *to be completed by physicians only*, is for members being treated for specific disease states, not including the above, and who will continue to require more than seven (7) prescriptions each month. A Licensed Clinical Professional will review each request. Please fax PAF requests to (805) 964-0367. If the member exceeds the monthly prescription limit and does not meet any of the above criteria, a medical request form (MRF) is required. Please fax all MRF requests to (805) 685-7781.

D2: Protocols for Home Infusion

Home Infusion Therapy is a covered benefit for CenCal Health members. Home Infusion Providers are a limited number of providers that are contracted as a pharmacy thru MedImpact and have an executed agreement as a Home Infusion Provider with CenCal Health's Provider Services Department. For these providers, CenCal Health has developed an infusion fee schedule billable by real-time online adjudication thru MedImpact.

CenCal Health's Home Infusion Network provides covered infused agents in the following therapeutic categories:

- Antibacterial/Antifungal Agents
- Parenteral Nutrition Solutions (TPN or Hyperalimentation)
- Heparin and Related Preparations
- Sodium and Saline Preparations
- Potassium Replacement
- Electrolyte Maintenance
- Protein Replacement
- IV Solutions: Dextrose-Water, Dextrose-Saline, Dextrose and Lactated Ringers
- Parenteral Amino Acid Solutions and Combinations
- Specialty Infused Products

All services for Home Infusion therapies will require Prior Authorization in the form of a Medical Request Form (MRF). Contracted Home Infusion Providers will submit a separate MRF for the drug being administered and each infusion per diem and/or nursing. Contracted Home Infusion Providers should note that the per diem rate includes all ancillary supplies and diluent drug products. Nursing visit requests are reviewed on case by case basis.

Details for each home infusion request can be found on the home infusion fee schedule provided to all contracted home infusion providers.

Requests for infused products from providers who are **not** contracted as a CenCal Health Home Infusion provider should submit the request to CenCal Health's Medical Benefit and not thru MedImpact.

Providers interested in the Home Infusion Network must be contracted with CenCal Health's PBM, MedImpact. For more information on how to contract as a home infusion provider please contact the CenCal Health Provider Services Department at (805) 562-1676.

D3: Mandatory Generic Substitution

CenCal Health generally mandates generic substitution when an AB rated equivalent generic product is available. In most programs, if a prescriber wants a brand name drug and issues a "do not substitute" order, he/she must submit a MRF for approval with a MedWatch form. This form can be found on the CenCal Health website at: www.cencalhealth.org.

The CenCal Health Pharmacy & Therapeutics (P&T) Committee recognizes exceptions to the mandatory generic policy where certain medications possess narrow therapeutic dose response characteristics. For a complete and up to date list, please see the Formulary at www.cencalhealth.org.

D4: Code 1 Restriction

Code 1 Restricted Drugs are drugs covered with a restriction that limits the use of a drug based on diagnosis, failure or intolerance to first line therapy, specific use of the drug, member's place of residence (i.e. Skilled Nursing Facility), or specialty of the prescriber. Formulary agents with a Code 1 Restriction are noted in the Formulary found at www.cencalhealth.org. Any other use of the drug is considered non-formulary and requires a MRF.

Although Code 1 Restricted Drugs do not require a MRF, the dispensing pharmacist is expected to contact the prescriber's office to document the Code 1 restriction when necessary. It is NOT sufficient for the prescription simply to have a "Code 1" on its face even if the prescriber apparently designates it. Information including the name of the person verifying compliance of the restriction with the prescriber, the date and time of the call, and the full signature of the pharmacist receiving such information must be kept with the prescription.

D5: Day Supply & Quantity Limits

CenCal Health permits prescription quantities to meet but not exceed a 31-day supply of medication unless specified as an exception to this rule. Please see the Formulary found at: www.cencalhealth.org.

Selected drugs have a quantity-dispensing limit that specifies duration of use or member age. A list of drugs that have quantity dispensing limits is contained in the Formulary found at: www.cencalhealth.org

Section E: Formulary Overview

The CenCal Health Formulary is updated on an on-going basis. The CenCal Health Pharmacy & Therapeutics (P&T) Committee meets quarterly and is responsible for reviewing additions, changes, and deletions to the Formulary. The P&T Committee updates and revises the Formulary based on sound clinical evidence, efficacy, safety and pharmacoeconomic considerations.

CenCal Health prescribers, pharmacists, or CenCal Health staff may request recommended formulary modifications. All suggested formulary modifications should be directed to CenCal Health.

The CenCal Health Formulary is available at CenCal Health's website at www.cencalhealth.org.

Section F: Medical Request Forms (MRFs) Process

CenCal Health has contracted with a Pharmacy Benefit Manager (PBM), MedImpact Healthcare Systems (MedImpact), to assist in the administration of the pharmacy management program including prior authorization requests. Every effort is made to process each MRF upon the initial submission.

Prescriptions for the following require a Medical Request Form (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
- Drugs exceeding the member age, dosing limit, quantity or duration of treatment dispensing limits.

MedImpact reviews MRFs who will approve, deny, or defer the request for more information. Under the direction of a clinical pharmacist, all MRFs that lack acceptable medical justification for the intended use of the drug will be denied.

F1: Medical Request Forms (MRFs)

CenCal Health utilizes the Medical Request Form (MRF). A copy of a MRF can be found in the Pharmacy section of the CenCal Health website at: www.cencalhealth.org. Providers may obtain MRFs by contacting CenCal Health at (800) 421-2560 extension 1080 or (805) 562-1080.

Providers who have questions regarding the MRF process may contact CenCal Health at (800) 421-2560 extension 1080 or (805) 562-1080.

F2: MRF Submission

MRFs are required to be completed by the prescriber and faxed to CenCal Health at (805) 685-7781. **Please submit only one drug per MRF.** Please fill the form out in its entirety. Required member information includes member's name, Member ID#, birth date, address and phone number, member Medicare eligibility and status.

- Required prescriber information includes: prescriber name, specialty, phone and fax numbers, DEA, NPI, address, and pharmacy name and fax number.

Under the heading of Requested Medication Information, include the drug name and strength, dosing schedule, diagnosis, estimated length of drug therapy, and diagnosis codes as well as fill in the retroactive request box if appropriate. If the request is retroactive, include the date and the reason for the retroactive request. In the following sections, explain why this drug is being requested and include previous medications tried; please be specific and thorough. Directly below is the space for the Prescriber's signature, please include the date in the box indicated after the signature.

F3: Timely Submission of MRFs

All MRFs must be received at CenCal Health within fifteen (15) business days after the requested start date of service.

F4: Retroactive MRFs

Retroactive MRFs received after fifteen (15) business days of the requested date of service may be considered for review only under the following conditions:

- When certification of the member's eligibility by the appropriate entity was delayed,
- When other coverage (e.g. Medicare or other health insurance) denied payment of a claim for services, or

- When a member did not identify himself/herself to the provider as a CenCal Health member by deliberate concealment or because of physical or mental incapacity to identify himself/herself.

If a member has obtained retroactive eligibility, CenCal Health must receive the MRF within sixty- (60) days of the member obtaining eligibility.

F5: Provider Notification of MRF Action

Inquiries regarding the status of a MRF may be directed to MedImpact at (800) 788-2949.

F6: Approved MRFs

The approved MRF is entered into the MedImpact system and faxed back to the Provider. The prescriber is responsible for notifying either the patient or the pharmacy filling the prescription so that the member can receive his or her medication in a timely manner.

F7: Denied MRFs

Written notification of a denied MRF that lacks medical justification for the intended use of the drug or a MRF deferred for more than fourteen (14) calendar days will be sent to the member and the prescribing physician within twenty-four (24) hours from the time of the decision. The Primary Care Provider (PCP), if different from the prescriber, will also be sent written notification of the denied MRF within twenty-four (24) hours from the time of the decision. If a pharmacy has been involved in the MRF process, the pharmacy will also be sent written notification of the denied MRF within twenty-four (24) hours from the time of the decision. The denied MRF will include the reason for the denial and information about the appeals process.

F8: Emergency After Hours Authorizations

CenCal Health members may receive emergency authorizations outside of CenCal Health's normal business hours (Monday through Friday, 8:00 a.m. to 5:00 p.m. PST) including weekends and holidays. MedImpact may authorize up to a five (5)-day supply of non-formulary medication, pending further authorization by CenCal Health. In an emergency, when authorization is not possible, CenCal Health will authorize a retroactive MRF allowing the pharmacy to dispense up to a seventy-two (72) hour supply of a non-formulary drug.

F9: MRF Completion

The MRF completion procedure allows only one drug per MRF.

Providers who have questions regarding the MRF process may contact CenCal Health at (800) 421-2560 extension 1080 or (805) 562-1080.

F10: Appeal of a Medical Request Form (MRF)

Please refer to Section 8, Provider Grievance System, of this manual for information.

Section G: Claims Submission

MedImpact Healthcare Systems (MedImpact) is the Pharmacy Benefit Manager (PBM) contracted with CenCal Health to process pharmacy claims for all of CenCal Health's eligible members. All routine prescription claims for CenCal Health members must be submitted through MedImpact.

Any routine prescription drug claims submitted directly to CenCal Health will be returned to the provider for submission to MedImpact.

All inquiries regarding claims submission, rejected claims, plan limitations, or CenCal Health's pharmacy benefit should be directed to MedImpact at (800) 788-2949.

The MedImpact Help Desk hours of operations are **7 days a week, 24 hours a day**.

G1: National Provider Identifiers (NPI)

All healthcare providers and plans are required to use and accept only National Provider Identifiers (NPIs) in standard transactions. The use of NPIs eliminates the need for health care providers to use different identification numbers to identify themselves when conducting standard transactions with multiple health plans.

For pharmacy providers, the NPI will replace the NCPDP (NABP) number in all transactions; however, pharmacies must register their NPI with the National Council for Prescription Drug Programs, Inc. (NCPDP) for MedImpact to recognize them. MedImpact validates the NPI based upon the pharmacy's NPI registration with the NCPDP organization. In addition, the NPI submitted must be uniquely associated with only one NCPDP.

G2: Electronic Claims Submission (ECS)

MedImpact's prescription claims processing is accomplished in a real-time point-of-sale process. MedImpact will only accept NCPDP D.0 claims. **The BIN Number or "Electronic Address" for MedImpact is 003585.**

Member information required for submitting online claims is as follows:

1. First and last name
2. Date of birth (DOB)
3. 9-digit ID number for SBHI
4. Relationship to cardholder ("01" for self, "03" for newborn and "04" for the twin until ID number obtained)
5. Gender

G3: Online Drug Utilization Review (DUR)

The online Drug Utilization Review (DUR) process assists pharmacists in providing quality care by identifying potential therapeutic conflicts. As claims are sent to MedImpact, the DUR process assesses the prescription against the claims history of the member. An online message is sent to the pharmacy when a potential problem is anticipated. If assistance is required regarding a DUR message, contact the MedImpact Help Desk at (800) 788-2949.

G4: Claim Form (30-1) Billing

Electronic Claims Submission (ECS) is the preferred method to submit claims to MedImpact. All claims not submitted by ECS **must** be submitted to MedImpact on a 30-1 or the Universal claim form. Other claim forms will not be accepted.

G5: Timeliness of Submitted Claims

Pharmacies have up to six (6) months from the date of service (DOS) to submit claims online to MedImpact. Pharmacies have up to six (6) months from the date of service (DOS) to bill paper claims to MedImpact. The exceptions to this policy are as follows:

- If a member was not eligible with CenCal Health at the time service was rendered and was subsequently granted retroactive eligibility, the 180-day billing limit is calculated from the date retroactive eligibility was established.
- If a member has other primary insurance and claims are processed by the primary insurance, the 180-day billing limit is calculated from the time the other insurance carrier rendered a payment determination. MedImpact must receive claims related to these circumstances no later than one (1) year from the month of service.

G6: Dispensed as Written (DAW)

MedImpact's online adjudication system only accepts DAW = 0 for all claims submitted by Electronic Claims Submission. CenCal Health requires generic substitution when an AB rated equivalent generic product is available. The only exception to DAW submission is for the following four (4) drugs that possess a narrow therapeutic dose response. When dispensing the brand name of these drugs, CenCal Health will accept either a DAW = 0 or DAW = 1, and the pharmacy will be reimbursed at the brand reimbursement rate.

- Lanoxin
- Dilantin
- Premarin
- Synthroid

Prescribers may order other brand name drugs with a "do not substitute" when there is clinical justification for doing so. In this case, submission of a Medical Request Form (MRF) by the prescribing physician is necessary. Those pharmacy providers who have difficulty submitting online claims with a DAW = 0 due to software limitations should contact the MedImpact Help Desk at (800) 788-2949 for claims submission assistance.

G7: Rejected Claims

Claims are frequently rejected due to the following:

- Code 1 Not Met
- Dispensed Too Soon
- Drug Not In Formulary

Although certain rejected claims may be payable when resubmitted after appropriate corrections have been made, it is the responsibility of all contracted pharmacy providers to consult the CenCal Health Drug Formulary for drug coverage status when rendering services to CenCal Health members.

G8: Return to Stock/Claim Reversal

Prescriptions filled and submitted for payment but not picked up by the member within a two (2) week period must be reversed using the online process. This requirement applies to unused and reusable stock in all types of pharmacies. Pharmacies are advised to maintain documentation of all reversals to demonstrate compliance with this requirement.

G9: Refill too Soon

Prescriptions refilled at a “too frequent” interval, based on days’ supply reported with the claim, will be rejected with a “Refill too soon” edit. A prescription is considered to be filled “too frequent” if less than 66% of the days’ supply submitted with the last fill has not elapsed.

When the prescriber has increased the amount of drug to be taken by a member, the pharmacy should call the MedImpact Help Desk at (800) 788-2949 to request an override.

G10: Refill too soon-Nursing Facility

MedImpact may approve a one-time override per medication within a one-year period for claims that reject for “refill too soon” if the member is being placed in a Nursing Facility and is not allowed to take their medications into the Facility with them. If a second request is made within the one (1) year, a Medical Request Form (MRF) must be submitted to CenCal Health for authorization review.

G11: Lost, Stolen, or Spilled Medications

MedImpact may approve a one-time override per medication within a one-year period for lost, stolen, or spilled medications. If a second request is made within one (1) year, a Medical Request Form (MRF) must be submitted to CenCal Health for authorization review.

G12: Vacation Supply

MedImpact may approve a one-time override per medication within a one-year period for a vacation supply of up to thirty-(30) days.

G13: SBHI/SLOHI Newborns

SBHI and SLOHI newborns are eligible for pharmacy benefits the month of birth and the ensuing month under the mother’s eligibility. Claims submissions for newborns should be under the mother’s nine-digit ID number using the newborn’s name and date of birth and a cardholder relationship of “03.” Claims submission after this period will require the newborn to be eligible under his/her own ID number. Please contact the Pharmacy Department at (805) 562-1080 for this to be updated in the MedImpact system.

G14: Provider Identification Number

All prescriptions submitted to CenCal Health must include the prescriber’s identification number. CenCal Health will reject claims submitted without a valid identification number. The physician identification number to be submitted shall be the prescriber’s National Provider Identifier (NPI). Prescriptions written by a Physician Assistant (PA), Nurse Midwife (NM), and Nurse Practitioner (NP) must meet State law and be submitted using the supervising physician’s NPI number.

CenCal Health continually evaluates pharmacies' compliance with providing accurate prescriber identification numbers. The accuracy of these numbers affects the effectiveness of CenCal Health's Drug Utilization Reports (DURs) and member drug profiling reports that are furnished to the members prescribing physician.

G15: Code 1 Restricted Drugs

A drug meeting the Code 1 restriction listed in the CenCal Health Drug Formulary must be processed online to MedImpact by placing a "07" in your computer software's Prescription Denial Override Field. This is the same designated override field used when submitting claims to EDS for State Medi-Cal. You will receive an online message defining the Code 1 restriction in place.

G16: Nutritional Products (Oral/Enteral)

Oral/Enteral nutrition is a Medi-Cal covered benefit when used in a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. Standard infant formulas are not a covered benefit. Standard infant formulas for normal infant nutrition are available through WIC. A Medical Request Form (MRF) is required for all nutritional products that are used on an outpatient basis. For additional information and clinical prior authorization, criteria please visit:

www.cencalhealth.org/providers/pharmacy/formulary.

G17: CenCal Health Carve-Out Medications

There are several drug classes carved out of CenCal Health's pharmacy benefit specified in the policy section of the State Medi-Cal provider manual as Capitated/Noncapitated services indicating coverage by fee-for-service Medi-Cal. In the classes, certain medications may require a TAR to be submitted to State Fee-For Service to obtain prior authorization.

These classes include:

- Selected HIV AIDS treatment drugs
- Selected alcohol and heroin detoxification and dependency treatment drugs
- Selected coagulation factors
- Erectile Dysfunction (ED) drugs
- Selected psychiatric drugs

Visit our website at www.cencalhealth.org and or the State Medi-Cal website www.medi-cal.ca.gov for a complete listing of the above referenced medications.

Section H: Coordination of Benefits (COB)

CenCal Health's health plan is always the payor of last resort. All pharmacy providers are required to bill the members primary insurance/or Medicare before billing CenCal Health.

Some CenCal Health members have prescription coverage through other payment sources. Examples of other coverage include Medicare Part D, Medicare HMO, or private health insurance, under which a member is entitled to receive prescription benefits. All CenCal Health pharmacy providers are required to bill other health coverage before billing CenCal Health. This is referred to as Coordination of Benefits (COB).

MedImpact's Point of Sale (POS) network is equipped to accept and adjudicate claims when there is a denial and/or partial payment from the other health coverage, and providers are encouraged to bill online for these services. Providers may neither refuse service to CenCal Health members who have other insurance coverage in addition to CenCal Health nor may they refuse service because of the requirement to hardcopy bill. Pharmacy providers are also prohibited from billing members for the copay amount or for a prescription, which is a primary insurance plan exclusion.

H1: Commercial COB

MedImpact's eligibility file will indicate when a member has other primary insurance coverage and will reject online prescription claims with the edit message "**Bill Primary Carrier First.**" The pharmacy should use the following procedure when this message is received:

- **Confirmation of other insurance coverage:** Confirm other primary insurance coverage status by requesting information from the member. If you are still unable to determine primary pharmacy coverage status from the member, call CenCal Health Member Services at (877) 814-1861 for additional assistance.
- **Claims submission when other insurance confirmed:** If the pharmacy determines that the member does have other pharmacy insurance coverage, the pharmacy bills the prescription claim to the primary insurance carrier first, before billing MedImpact. If a balance remains after payment by the primary carrier, MedImpact is then billed. These secondary billings will include copayments, deductibles and items not covered by the primary carrier. The secondary billing should include the full amount charged for the item, and the amount paid by the primary insurance carrier. Electronic billings that do not include attachments must be self-certified by entering an appropriate and valid Other Coverage Code as described in the Medi-Cal Provider

Manual; however, providers must still be able to readily retrieve all backup documentation including proof of claim submission and payment. If the pharmacy is not equipped to submit secondary billings online, they may submit a paper claim to MedImpact by completing a 30-1 Pharmacy claim form attached to documentation of the paid amount from the primary insurance. (Be aware that MedImpact may impose additional processing charges for processing paper claims.) Documentation may be either the primary insurance Explanation of Benefits (EOB), or a copy of the pharmacy's adjudication screen.

MedImpact does not pay insurance copayments separately. Copayments must be billed on a claim that shows the full amount charged by the pharmacy to the primary carrier, amount the primary carrier actually paid, and valid other coverage code as described in the Medi-Cal Provider Manual. MedImpact will not pay the balance of a pharmacy's bill when the pharmacy has an agreement with the other health coverage carrier or plan to accept the carrier's contracted rate as "payment in full". Please do not bill for these services.

MedImpact will accept secondary billings for all prescriptions approved for payment by the primary insurance carrier regardless of whether the drug is a CenCal Health formulary item or not; a MRF (Medical Request Form) is not required for secondary billing.

- **Claims submission for prescriptions not covered by other insurance:** If the prescription is not on the primary insurance formulary, then the pharmacy must pursue normal procedures to obtain a prior authorization from the primary insurance carrier. If the prior authorization is denied and an alternative primary insurance formulary drug cannot be used and the drug is on CenCal Health's formulary, the pharmacy may then electronically bill the prescription claim to MedImpact by entering the appropriate other coverage code which reflects non coverage by the primary carrier. Otherwise the pharmacy may bill on a 30-1 form as instructed in the Medi-Cal Pharmacy Provider Manual. If the prescription is denied by the primary insurance carrier and the medication is not on CenCal Health's formulary, then an approved MRF from MedImpact is required for payment.
- **Claims submission for other insurance plan exclusions:** If the primary insurance carrier does not cover the prescription as a plan benefit and the drug is on CenCal Health's formulary, the pharmacy may then bill the prescription claim to MedImpact with documentation of a plan exclusion. For example, many insurance carriers do not cover OTC or medical supply items, whereas CenCal Health does cover these items.

If the prescription is a primary insurance plan exclusion and the medication is not on CenCal Health's formulary, then an approved MRF from MedImpact is required for payment.

- **Member does not have other primary insurance:** If the pharmacy determines that the member does not have other pharmacy insurance coverage or other pharmacy insurance benefits have been exhausted, a completed Eligibility Update Form should be faxed to CenCal Health Recoveries Unit at (805) 964-0540. Please attach a copy of the pharmacy adjudication screen showing the claim was rejected due to "No coverage". If the pharmacy is unable to produce a copy of the denial, they should call CenCal Health Member Services for assistance at (877) 814-1861. Member Services staff will then research the primary insurance prescription coverage status and initiate a change to the MedImpact eligibility file if the member is found not to have primary pharmacy insurance coverage.
- **Billing Notes:**
Completion of the 30-1 Form: if you are unable to bill electronically and must submit a paper claim, please refer to the Pharmacy Claim Form Completion section in the State Medi-Cal Pharmacy Manual.

Mail all completed paper claims to:

MedImpact Healthcare Systems, Inc.
Operations Dept. Attn: Claims
10181 Scripps Gateway Ct.
San Diego, CA 92131

H2: Medicare COB

Some CenCal Health members have primary coverage for prescriptions through Medicare Part B & D. If the member has Medicare coverage, the pharmacy must submit claims for Medicare-covered drugs/supplies to the Medicare carrier as the primary insurance. CenCal Health requires that participating pharmacy providers accept assignment on all Medicare/CenCal Health Medi-Cal claims billed on the member's behalf. The assignment acceptance is an agreement with Medicare that the provider will not charge the member, including coinsurance and deductible amounts, and will accept Medicare's determination of approved charges.

- **Drugs and supplies covered under Medicare Part B:** Most drugs covered under Medicare Part B are drugs that require the intervention of a physician to administer properly. These include immunosuppressant drugs, anti-cancer drugs, antiemetic drugs, and drugs and dialysis drugs.

Pharmacy providers are encouraged to verify coverage through other reference sources and/or by contacting the Medicare fiscal intermediary. Other drugs, medical supplies, biologicals, blood modifiers and nutritional therapies covered by Medicare, and are not on the CenCal Health formulary, will not require a MRF. Please refer to your Medicare Supplier Manual for a detailed listing of these items.

H3: Claims Submission Procedure for Medicare Covered Drugs/Supplies

1. MedImpact's eligibility file will indicate when a member has Medicare coverage and will reject online prescription claims for Medicare covered drugs with the edit message "**Must Bill Medicare**".
2. The pharmacy bills Medicare according to the billing instructions as provided by Medicare. Once the Pharmacy has received payment or denial from Medicare, they may then bill for any denied services or for a member's Medicare copay and/or deductible. The claim should be sent to MedImpact electronically or on a Pharmacy claim form (30-1) along with the Medicare EOMB information.

Mail all completed paper claims to:
MedImpact Healthcare Systems, Inc.
Operations Dept. Attn: Claims
10181 Scripps Gateway Ct.
San Diego, CA 92131

Section I: Provider Grievance System

Procedure: Processing Provider Inquires, Appeals and Complaints

A process has been established for providers to have their inquiries, appeals and complaints heard and evaluated.

I1: Definitions

Inquiry: A request by a Provider for clarification, or a request for additional information.

Appeal: An appeal is a request from a Provider to change a previous decision made by CenCal Health. Appeals by Providers are made to MedImpact regarding Medical Request Forms (MRFs).

Complaint: A complaint is an oral and/or written expression of dissatisfaction.

I2: Receipt and Resolution of a Provider Inquiry

The appropriate Department to address the inquiry, unless otherwise requested, shall review and respond by telephone to inquiries directed to CenCal Health's attention.

I3: Pharmacy Claims Processing Decision

Providers may contact CenCal Health's Pharmacy Benefits Manager (PBM), MedImpact, regarding a pharmacy claims processing question, including a pharmacy claim denied for reasons other than lack of a MRF. Most of these inquiries are resolved at the initial contact and are not formally documented. The Provider may submit additional information to MedImpact to adjudicate the claim in question.

I4: Appeal of a Medical Request Form (MRF)

Providers may appeal denied or modified MRFs on behalf of the member by submitting the following documentation including written consent from the member to file on their behalf within sixty (60) calendar days from the date of the original decision:

A copy of the original or modified MRF;

- A copy of the original or modified MRF
- A letter stating why denial or modification should be overturned;
- Documentation to support overturning the original denial or modification.
- Written Consent from Member
- A new completed MRF

Providers/Members are notified of receipt of their appeals and the appeals process within five (5) working days.

The appeal decision shall be reviewed by the Medical Director or a qualified licensed Medical Director designee physician who may reverse the denial. The Provider will receive a written response within thirty (30) calendar days of receipt regarding the final determination of the appeal. If the service has not been provided, the provider may inform the member of his or her right to file an appeal by contacting CenCal Health's Member Service Department:

CenCal Health
Member Services Department
4050 Calle Real
Santa, Barbara, CA 93110
1-877-814-1861 (Toll-Free)

For the hearing impaired, use the California Relay Service at
711 or
TTY: 1-833-556-2560
8:00 a.m. to 5:00 p.m. - Monday through Friday

15: Expedited Appeals

When the member's condition is such that the member faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb or other major bodily function, or timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function, decisions shall be made in a timely fashion not to exceed 72 hours after the CenCal Health's receipt of information necessary and required to make the determination. Expedited appeals may be initiated by the member or by the provider acting on behalf of the member. Expedited appeals are performed by CenCal Health only when, in the judgment of CenCal Health, a delay in decision making might seriously jeopardize the life or health of the member.

The provider will be notified in writing of the expedited appeal within twenty-four (24) hours of the decision. Written confirmation of the decision will be provided within two (2) working days if the initial decision was not in writing.

For additional information about MRF appeals, please call (805) 685-9525, extension 1661.

16: Post Service Appeals

If a provider receives a letter of denial or modification of a MRF for a Post Service Request, the provider may contact the physician reviewer or licensed health care professional by calling or writing to the address and/or the telephone listed below:

CenCal Health
Pharmacy Services Department
4050 Calle Real
Santa Barbara, CA 93110
(805) 562-1639

If the service has not been provided, members are informed of their right to file an appeal. For additional information or assistance, members may contact CenCal Health's Member Services Department at:

CenCal Health
Member Services Department
4050 Calle Real
Santa Barbara, CA 93110

1-877-814-1861 (Toll-Free) or
California Relay Service at 711 for the hearing
impaired or
TTY: 1-833-556-2560
8:00 a.m. to 5:00 p.m. Monday through Friday

I7: Receipt and Resolution of a Provider Complaint

The Provider Services Department is charged with the resolution of Provider Complaints. The Complaint may be related to: Member Issues, Another Provider's Care or Treatment, a Clinical or Quality of Care Issue, Aspects of CenCal Health's administration of its programs, or other issues. The Provider may file a complaint with the Provider Services Department via a telephone call, by fax or through other written means.

The Provider Services Representative (PSR) will determine whether the complaint involves an adverse or potentially adverse effect on a member's quality of care. Any complaints involving a clinical or quality of care concern will be referred to the Supervisor, Clinical Practice Management, the Supervisor, Clinical Practice Management will attempt, under the direction of CenCal Health's Medical Director, or Designee, to respond to the issue as quickly as possible in a time frame appropriate to the member's medical condition. The Supervisor, Clinical Practice Management shall:

- Obtain Provider(s) perspective and/or medical records regarding complaints that are potentially clinical complaints.
- Present gathered information for review by the Medical Director or Designee, and/or the Credentials and Peer Review Committee, etc.
- Document the results of the investigation and resolution

If the Provider submits a written formal grievance, the PSR will notify the Provider Services Quality Liaison, who will send a receipt acknowledgment letter within five business days.

The PSR will collaborate with other staff as needed to investigate and resolve the Provider's Grievance. Following resolution of the complaint, the PSR will document the case and the outcome, and the Quality Liaison will send a resolution letter. All grievances shall be resolved within 45 business days.

18: Provider Complaints Requiring Clinical Quality of Care Review

CenCal Health's Supervisor of Clinical Practice Management Nurse or Designee shall be responsible for reviewing clinical complaints when anyone has reported an adverse or potentially adverse effect on a member's health.

The Clinical Practice Management Nurse or Designee shall:

1. Obtain Provider(s) perspective and/or medical records regarding complaints that are potentially clinical complaints.
2. Present gathered information for review by the Chief Medical Officer or designee, and/or the Peer Review Committee, etc.
3. Document the results of the investigation and resolution.

19: Disclosure to Providers and Members

Providers are informed of CenCal Health's Provider Grievance System through their Provider contract agreements or amendments, CenCal Health's website at www.cencalhealth.org, Provider Bulletins, and in Provider materials and manuals issued by CenCal Health and updated periodically. Additionally, denial of claims payment is indicated on the Provider's Explanation of Benefits (EOB).

All written communications to a physician or other health care provider of a denial, deferral, or modification of a MRF shall include the name and direct phone number or extension of the health care professional responsible for the denial, deferral, or modification. The response will also include information as to how the member may file an appeal or complaint with CenCal Health, and in the case of Medi-Cal members when the service has not yet been provided, shall explain how to request an administrative hearing.

If CenCal Health, or a complaint has not satisfactorily resolved the Provider's complaint or appeal or appeal remains unresolved for more than thirty (30) days without written notice, the Provider may submit the complaint or appeal in writing to CenCal Health's Chief Executive Officer (or designee) who will determine whether it warrants review by the Board of Directors. If the Provider's request involves an exception to DHCS or DMHC regulations, the Provider must include justification for such an exception in order for it to be presented to the Board of Directors. 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 Deputy Executive Director should be notified immediately when a Provider's legal representative contacts CenCal Health regarding the pursuit of legal action to resolve a complaint or appeal.

I10: Confidentiality and Privacy Record Retention

All Provider complaints and appeals shall be placed in designated files and maintained by the PSQI Manager for at least five (5) years after the resolution; the files of the previous two (2) years shall be in an easily accessible place at CenCal Health's offices. Documents that are considered "confidential" and that are obtained during a clinical appeal or quality of care review will be maintained by the Health Services Department in appropriate files, folders, or binders.

I11: Monitoring the Process-Reports

The PSQI Manager will prepare a quarterly summary of Provider Grievances to be presented to CenCal Health's Provider Advisory Board, Network Management Committee, and Board of Directors. The Provider Grievances summary shall summarize the number and type of Provider appeals and complaints.

Section J: Pharmacy Audits

CenCal Health maintains an ongoing Pharmacy Audit Program to ensure pharmacy, member, and prescriber compliance with CenCal Health's program policies and procedures.

J1: Audit Triggers

The Audit Program is supported by continuous in-house analysis of statistical dispensing triggers. These triggers include, but are not limited to:

- Average claim amount
- Quantity dispensed versus days' supply
- Ratio of usual & customary billing to amount calculated payments
- Claim reversals
- Total number of rejects
- Use of physician identifiers
- Controlled drug percent
- Generic percent
- Refill percent
- Average number of prescriptions per member.