E1: Covered Services Overview

E2.1: Acupuncture Services

E2.2: Audiology Services

E2.3: Chiropractic Services

E2.4: Hearing Aids Services

E2.5: Home Health Services

E2.6: Hospice Services

E2.7: Incontinence Supplies

E2.8: Laboratory Services

E2.9: Lactation Services

E2.10: Nursing Facility

E2.11: Nutrition Educators

E2.12: Optician Services

E2.13: Optometry Services

E2.14: Vision Services

E2.15: Physical Therapy Services

E2.16: Emergency Medical Transportation Services

E2.17: Durable Medical Equipment

E2.18: Medical Supplies

E2.19: Occupational Therapy

E2.20: Orthotics and Prosthetics

E2.21: Speech Therapy

E2: Limited Services

E3: Adult Preventive Services

E4: Pediatric Preventive Services

E5: Child Health and Disability Prevention (CHDP) Program

E6: Behavioral Health Treatment

E7: Mental Health Services

E8: Substance Use Services

E9: Non-Emergency Medical Transportation Services and Non-Medical Transportation

E10: Importance of Fluoride Varnish

Section A: Introduction

A1: Welcome to CenCal Health

CenCal Health is a County Organized Health System (COHS) model for California's Medi-Cal Managed Care Program that administers health insurance programs for Santa Barbara County and San Luis Obispo County. All Medi-Cal beneficiaries in the service area are automatically enrolled into a COHS program and each COHS is created by a county board of supervisors and governed by an independent commission. We work with a vast network of dedicated and compassionate doctors, pharmacies and other types of providers and facilities that take care of our members. CenCal Health provides health coverage for 1 in 4 people in Santa Barbara County, and 1 in 5 in San Luis Obispo County. We provide services to children, low-income families, seniors, and persons with disabilities. CenCal Health's insurance programs are built on a foundation of comprehensive and coordinated patient-centered care through the collaboration of physicians, care managers, and other healthcare providers. Our aim is to help our members obtain quality healthcare.

CenCal Health recognizes the strength of our programs depends upon strong collaboration and communication with our provider partners and their staff. We look forward to working with each provider and their staff to provide our members with high quality, cost-effective care. CenCal Health is a COHS plan that manages programs funded by the State and Federal governments, and operates

independently. CenCal Health is governed by a Board of Directors appointed by the San Luis Obispo County and Santa Barbara County Boards of Supervisors, and is made up of members, providers, business leaders, and local government representatives.

A2: Intent of this Manual

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

CenCal Health uses State policies determined by the Department of Health Care Services (DHCS) to administer Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI). CenCal Health interprets and modifies the policies with the approval of our Board of Directors. This Provider Manual contains policy information for the SBHI and SLOHI programs. DXC Technology Services, LLC maintains the Medi-Cal Provider Manuals that offer specific guidelines for the State Medi-Cal program.

CenCal Health drafted the Provider Manual as a tool to easily search via the Table of Contents page or through our website. Providers can search for particular topics by reviewing any line item or page number in the table of contents.

We encourage providers to become familiar with the contents of the Provider Manual and to refer to it frequently. Please contact the Provider Services Department with any suggestions for additions or improvements to this Provider Manual at (805) 562-1676.

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

Reference Link:
Department of Health Care Services (DHCS) Medi-Cal Manual
https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx

A3: Overview of CenCal Health Programs

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

Medi-Cal ensures that children and adults with limited income and resources can receive physical and behavioral health services at little or no cost.

This low-income program includes:

- Families with children
- Foster care children
- Pregnant women
- Doula services
- Childless adults
- Seniors
- Persons with disabilities

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

Eligibility for Medi-Cal is month-to-month. Medi-Cal recipients must re-certify their eligibility periodically. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Please note that a member's eligibility must be verified before delivery of services and that the CenCal Health identification card alone is not a guarantee of eligibility. Please refer to Section G: Eligibility Verification and Enrollment of the Provider Manual for further eligibility information or verify on CenCal Health's website.
Not all Medi-Cal beneficiaries are CenCal Health members. Those who are not CenCal Health members are eligible under the Medi-Cal Fee-For-Service system (FFS Medi-Cal). Providers seeing these beneficiaries would bill and be reimbursed directly for covered services by Affiliated Computer Services, the state Medi-Cal fiscal intermediary.

Reference Link:
CenCal Health Provider Eligibility Resources
www.cencalhealth.org/providers/eligibility/

A4: Glossary of Terms

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

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

A5: Provider Bulletin

The Provider Bulletin is a quarterly printed publication and sent by email monthly and provides information on changes to the Medi-Cal program, new programs, benefit

changes, claims information, clinical updates, educational opportunities, and more. This newsletter contains information useful to front office, back office, and medical personnel. It is available to all contracted providers in paper via the US Mail, as well as digitally via email and online.

Individual provider staff can sign up to receive an electronic newsletter via email by signing up through the registration form.

Non-contracted providers do not receive the monthly US mailed publication, however do have the ability to sign-up for the electronic newsletter via email.

Reference Link:
Provider Bulletin Library
https://www.cencalhealth.org/providers/provider-bulletin/

A6: CenCal Health Mission, Vision, and Values

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

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

Our Values:

- **Improvement**
  Continually improving to ensure our growth, success and sustainability
- **Integrity**
  Doing the right thing, even and especially when it is hard
- **Compassionate Service**
  Serving and advocating for all customers with excellence
- **Collaboration**
  Coming together to achieve exceptional results

A7: 2023-2025 CenCal Health Strategic Plan

CenCal Health is pleased to share our 2023-2025 Strategic Plan and emerging vision, which prioritizes working with you, our community partners.

Our priorities are to cultivate community partnerships, advance quality and health equity for all, and expand our service role and reach through the transformational and ground-breaking CalAIM program. This requires that we organize for impact and effectiveness both now and in the future. The guidance CenCal Health offers and the priorities it sets have been thoughtfully considered through a broad and inclusive process that began with hearing your voices and then extended to a wide array of stakeholders, including community leaders, local stakeholders, our provider partners and the members we serve.

Within CenCal Health, we are committed to achieving our Strategic Plan, recognizing that it serves as an important framework going forward. **The value of a local health plan to Santa Barbara and San Luis Obispo counties is more important than ever.** As we turn our attention to the journey we collectively embark on over the next three years, we look forward to collaborating closely with you, the community partners that work so tirelessly to improve the health and well-being of our communities.

To read the complete 2023-2025 Strategic Plan, visit cencalhealth.org/strategicplan.

Section B: Provider Resources

B1: CenCal Health Contact Information

Contact Information	Phone Numbers
Member Services	☎ (877) 814-1861
Provider Services	☎ (805) 562-1676 ☎ (800) 421-2560 ext. 1676 providerservices@cencalhealth.org
Claims Operations	☎ (805) 562-1083 ☎ (800) 421-2560 ext. 1083 cencalclaims@cencalhealth.org
Medical Management	☎ (805) 562-1082 ☎ (800) 421-2560 ext. 1082 ☎ (877) 931-2227 Care to Care Radiology Benefit Manager ☎ Utilization Management (805) 562-1082 Option 1 ☎ Case Management (805) 562-1082 Option 2 ☎ Adult Disease Management (805) 562-1082 Option 4 Pediatric Case Management & CCS (805) 364-4950 ☎ Behavioral Health (805) 562-1600 Secure Link: https://gateway.cencalhealth.org/form/bh ☎ CalAIM Enhanced Care Management (ECM) & Community Supports (CS) Services (805) 562-1698

Population Health	☎ (805) 617-1997 populationhealth@cencalhealth.org
Pharmacy Services	☎ (805) 562-1080 ☎ (800) 421-2560 ext. 1080
Video & Telephonic Interpreter Services	☎ Phone Interpreter Service (800) 225-5254 Operator Customer Code: 48CEN Video Remote Interpreter Service Web Address: **cencalhp.cli-video.com** VRI Access Code: 48cencalhp ☎ (877) 814-1861 - Sign Language
Finance-Recoveries Unit	☎ (805) 562-1081 ☎ (800) 421-2560 ext. 1081
Fraud, Waste & Abuse Reporting	☎ Compliance Hotline: 1 (866) 775-3944 Mail: CenCal Health Attn: Compliance Investigator 4050 Calle Real Santa Barbara, CA 93110 compliance@cencalhealth.org

Reference Link:
Medi-Cal Provider Manuals are available on the Department of Health Care Services website.
http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

CenCal Health Contact Us
www.cencalhealth.org/contact-us/

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

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

B2: Provider Resources on CenCal Health's Website

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

- Contracted providers may use CenCal Health Provider Portal Restricted website to verify eligibility, check the status of CenCal Health claims, and

submit authorizations. Providers must register with CenCal Health to utilize this restricted site.

- Provider Manual - Provides general information relative to the provision of healthcare goods and services to CenCal Health members.
- Provider Directory - Search by CenCal Health program, health network, name, specialty, or location.
- Health and Wellness - Materials are available in PDF format and downloadable in all of CenCal Health's threshold languages.
- Provider Communications - This includes the monthly provider newsletter, as well as Provider Updates based on recent information received by the Department of Health Care Services.
- CenCal Health Policies and Procedures - A complete library of CenCal Health policies by program located in the 'Forms, Manuals and Policies' section of the website.

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

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

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

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

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

B3: Provider Education and Training Resources

CenCal Health provides education and training on a variety of topics to CenCal Health's provider network to facilitate the relationships between CenCal Health and the providers, and also between the providers and the members to improve the quality of care and services our members receive.

Our training events are primarily developed and presented by the Provider Services Department with input from other departments and may feature a guest speaker. The training events are continually updated to reflect the most current information available.

The Provider Services Department hosts the training events; issues invitations; and arranges the time, and locations. Webinar/online trainings are also hosted and recorded so they are made available on our website under Provider Training & Resources. The trainings conducted may consist of one or more speakers, visual

and/or audio aids, and handouts. The length of the program varies depending on the content and concludes with a question and answer period.

New Provider Orientation (NPO) - When a new provider contracts with CenCal Health, the Provider Services Representative (PSR) conducts a training which the provider is given instruction and materials to help them become acquainted with CenCal Health's programs, the billing processes, provider/member grievance policy, member eligibility, Cultural Competency, Seniors and Persons with Disabilities, DEI, Linguistic & Interpreter Services, authorizations, provider portal website demonstration, etc.

The NPO training is offered within 10 working days and completed 30 calendar days after the provider is placed on active status. A CenCal Health onboarding packet, and the Provider Manual is made available to the provider during onboarding, and inclusive of a full review of CenCal Health's website. The orientation and Provider Manual provided contains information so the provider can begin to provide care and services to the members of CenCal Health's programs, and a New Provider Training Attestation Form is signed stating that they received such material. The PSR is available by phone and e-mail for questions, and will make return visits as needed, in person or virtually.

Provider In-Service Office Visits & Training Visits - PSRs routinely visit provider offices on an informal basis to help maintain a mutually beneficial relationship between the provider and CenCal Health. These visits create opportunities for the provider to ask questions and for the PSR to deliver current information or materials. Meetings may be scheduled at the provider's request and convenience to discuss specific issues. CenCal Health's PSR, Member Services Representative, Claims Representative, Quality Representative, and Health Service's Population Health staff may be included in these meetings.

CenCal Health Provider Orientation - This is a refresher training which covers a multitude of topics including CenCal Health's programs, provider/member grievance policy, member eligibility, Linguistic & Interpreter Services, Behavioral Health & Mental Services, Transportation Benefit, Health Education resources, Cultural Competency, SPD, DEI and provider resources. This training course is an ad hoc refresher training course to ensure new staff are adequately informed.

Claims Billing - This training is coordinated by a CenCal Health Claims Service Representative for office staff that are unfamiliar with medical billing for CenCal Health, and provides individualized assistance with claims submissions. It is provided as needed and is tailored to the provider's needs. This individualized training is usually the result of a provider's request for in-depth instruction or due to problems noted by the CenCal Health Claims Department that results in excessive numbers of the provider's claims being pended or denied.

Facility/Medical Record Audit - CenCal Health's Quality Management Coordinator (QMC) assists PCP sites in preparing for Facility and Medical Record Audits as required by DHCS. Audit tools, relevant policies and procedures, and other related

materials are provided to the PCP site when an audit is scheduled, and the QMC contacts the PCP site to discuss critical elements and answer questions prior to the audit date.

Quality Improvement Health Equity Trainings - These trainings are held to focus on various tools to assist providers in their role as case manager, and to assist in providing additional education for program improvement projects. Quality programs include education on a variety of topics such as Quality of Care Incentive Program (QCIP), Asthma Management, and Adult/Adolescent Well Care.

CenCal Health Member Eligibility Overview Training - Provider staff learn how to manage a CenCal Health Member's eligibility, education on Share of Cost (SOC), CCS members, how to check eligibility status, and learn the many different resources you can utilize with checking eligibility status via the provider portal. This training includes a live demonstration of the provider portal and how to use its features. This training may also be scheduled at the provider's request via an In-Service training with a PSR.

Authorization Overview Training – Provider staff learn about Referral Authorization Forms (RAFs), Treatment Authorization Requests (TARs) and other types of authorizations that may be required for review for medical necessity. During this training, staff receive a demonstration of the provider portal and how to use the provider portal tools to submit forms online, and check authorization status. This training may also be scheduled at the provider's request via an In-Service training with a PSR.

Targeted Programs (New Initiatives) - There are a variety of programs offered to specific audiences, or specific topics that may be conducted annually or on an as-needed basis. They are usually developed to serve an identified need or to inform certain provider types of provider-specific issues. These may include training events specific to information on changes to CenCal Health's programs.

Cultural Competency, Health Literacy and Communicating with Seniors and Persons with Disabilities Training - cultural competency and health literacy tools provide appropriate health care and services for our members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups. In addition, The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities. Both public and private hospitals and health care facilities must provide services to people with disabilities in a nondiscriminatory manner. CenCal Health provides yearly Cultural Competency, Health Literacy and Seniors and Persons with Disabilities (SPD) education to improve provider-patient communication, and Diversity, Equity, and Inclusion (DEI) training.
This process shall include an educational program for providers regarding health needs specific to this population that utilizes a variety of educational strategies,

including but not limited to posting information on websites as well as other methods of educational outreach to providers during an NPO Training.

Attendee Tracking: Attendees are required to register for online webinars, and in-person trainings and then tracked for participation. If hosted in person, attendees are given name badges, and asked to sign an attendance sheet. This allows the Provider Services Department to maintain records of attendance and provide a roster from which certificates of attendance or completion may be issued.

Confidentiality and Privacy: No personally identifiable information is used or released during these training events. Blinded information may be used, or "dummy data" may be created, for demonstration purposes.

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

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

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

B4: Advanced Health Care Directive

CenCal Health members should fill out an Advanced Health Care Directive. It is a simple form that tells doctors and loved ones exactly what type of care a patient wants at the end of their life, or if they cannot speak for themselves. CenCal Health has a free, simple, and member-friendly form that is available on our website. Members can print it out, complete the form, and sign it. Then they should give copies to their doctor(s), family, and/or friends. This will make sure that the member's values and choices are met. To download the easy-to-use Advanced Health Care Directive form in English or Spanish, please visit the CenCal Health website at www.cencalhealth.org.

If members cannot print the online form, we can send them a free copy. Please contact CenCal Health's Health Education Request Line at **(800) 421-2560 ext. 3126.**

Reference Link:
CenCal Health Advanced Health Care Directive site and forms:
https://www.cencalhealth.org/health-and-wellness/advanced-healthcare-directive/

B5: Community Resources

Please note that CenCal Health is providing information as a resource only. It is not our intention to imply that organizations offer services that are covered benefits for our members.

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

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

B6: Telemedicine Policy

CenCal Health will reimburse for care delivered via telemedicine per DHCS guidelines. Please see DHCS telemedicine billing FAQ for more information.

- Capitated providers: Telemedicine services will be included in capitation payment.
- FFS providers: Telemedicine services will be paid at the contracted rate.
- BH providers: Telemedicine services for mental health is allowable. If you are a FQHC and offer mental health services, please submit your claims with the Medi-Cal allowable codes. Visit DHCS's website and search "COVID-19 Medi-Cal Services and Telemedicine
  Notice."

Virtual Communication (audio and video)

Providers should continue to attempt to provide telemedicine services via HIPAA-compliant telecommunications methods. However, according to the Department of Health and Human Services (HHS) issued on March 23, 2020, "…covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telemedicine without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telemedicine during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications."

We ask that you notify our Provider Services Department by email providerservices@cencalhealth.org if you intend to provide services over an electronic platform.

Telephonic Communication (audio alone)

This includes a brief communication with another practitioner or with a patient, who in the case of COVID-19, cannot or should not be physically present (face-to-face). Medi-Cal providers may be reimbursed using the below Healthcare Common Procedure Coding System (HCPCS) codes G2010 and G2012 for brief virtual communications.

HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and management (E/M) service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

Additionally, CenCal Health will waive the authorization requirement for ages 21 and over for CPT codes 98966-98968 to support providers in delivering care by telephone without video through June 30, 2020.

Section C: Contracting and Credentialing

C1: Join the CenCal Health Network: Provider Contracting

Join us in our effort to provide quality healthcare to those in need. Please contact our Provider Services Department at (805) 562-1676, or email provideronboarding@cencalhealth.org to determine documents required.

To be reimbursed for non-emergent services for an eligible member of a health program administered by CenCal Health, providers must be credentialed by, and have a fully executed contract with CenCal Health. To provide emergent care to any Medi-Cal member, providers need only be enrolled in the State Medi-Cal program.

CenCal Health is required by federal law to ensure all contracted providers are enrolled in the DHCS Medi-Cal Program. Providers who enroll through DHCS are eligible to provide services to Medi-Cal Fee for Service (FFS) beneficiaries as well as CenCal Health Medi-Cal beneficiaries. The State's Provider Application and Validation for Enrollment (PAVE) portal is a web-based application designed to simplify and accelerate the State Medi-Cal enrollment process. Providers can utilize the PAVE portal to complete and submit applications, report changes to existing enrollments, and respond to requests for continued enrollment or re-validation.

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

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

Your PSR, as well as staff from other CenCal Health departments, will be available to answer questions, complaints, and concerns, assist with member issues, process claims and authorizations for referrals and/or treatment, and for on-going training.

Reference Links:
Department of Health Care Services (DHCS) PAVE Provider Enrollment
www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

C2: Provider Directory and Attestation of **Practice Information**

The Department of Managed Health Care (DMHC) released Senate Bill (SB) 137 in December 2016, indicating uniform standards and timely updates for all Managed Care Plan Provider Directories. Provider directory standards allow members to receive and search accurate, up-to-date information regarding physicians, hospitals, clinics, and other providers contracted with CenCal Health's network.

Among other requirements, SB 137 requires CenCal Health to do the following:

- Publish and maintain accurate provider directory or directories with information on contracting providers.
- Verify provider directory information with contracted providers on a periodic basis.
- Update the provider online directory weekly and printed directory quarterly.
- Ensure contracted providers notify the Health Plan when they are accepting new patients or no longer accepting new patients.

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

For any questions regarding attesting to your data, you can contact the Provider Services Department at (805) 562-1676 or send an e-mail to providerservices@cencalhealth.org.

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

C3: Credentialing and Recredentialing

CenCal Health always strives to provide the best care possible to our members. Like most managed care organizations, we have programs in place to improve the quality of care delivered to our members. As part of this quality improvement program, we have a process to gather and verify the credentials of providers in our network.

CenCal Health developed and implemented a credentialing and recredentialing process to evaluate the practitioners who practice within its delivery system initially and on an ongoing basis. We have chosen to implement a rigorous credentialing process because we assume responsibility for managing the healthcare of our members, and ensuring our providers meet quality standards is part of this responsibility. Well-defined policies and procedures identify the practitioners that are subject to this process, define the credentials assessed and methodology used to make credentialing decisions, and identify the parties responsible for the credentialing process. Information assessed includes (but is not limited to) licensure, relevant training or experience, and any issues that may affect the care delivered within the managed care setting. Verification of this information from approved primary sources is essential to ensure that decisions are based on the most accurate, current, and complete information available. At recredentialing, CenCal Health also considers data derived from practice experience within the organization as part of its evaluation, as well as complaints and other member satisfaction measures.

To ensure that CenCal Health has obtained correct information and makes fair credentialing decisions, practitioners are afforded certain rights during the credentialing and recredentialing process, including the right to review information obtained to support their credentialing application.

CenCal Health's credentialing process is based on National Committee of Quality Assurance (NCQA) standards. In some instances, the credentialing and recredentialing process may be delegated, wholly or in part, to another entity, with oversight by CenCal Health to ensure the same standards are being met.

C4: Primary Source Verification

	MD/DO	Chiropractor	DPM	Physician Executive	PA/PA-C	NP	CRNA	Nurse Midwife	Allied	Orgs
NPI (PSV) /SSN / DOB / Full name	√	√	√	√	√	√	√	√	√	NPI / Tax ID / W9
Medical/professional school	√	√	√	√	√	√	√	√	√	N/A

Internship/Residency/ (Fellowship optional)	√	One year	√	√	N/A	N/A	N/A	N/A	N/A	N/A
Board Certification (not required unless otherwise stated) (PSV w/in last 6 mos.)	ABMS	N/A	ABFAS ABPM	ABMS	NCCPA (required at grad., renewal optional)	AANP ANCC NCC PNCB	NBCRNA (required)	AMCB (required for CNM)	N/A	N/A
Specialty / Degree (based on residency, fellowship or board cert.)	√	√	√	Specialty Physician executive	Specialty based on activity	Specialty based on activity	√	√	√	Accreditation
License (State) (PSV w/in last 6 mos.)	√	√	√	√	√	√	√	√	√	Business License
License (National)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	√	RD's	N/A
License (other states)	√	√	√	√	√	√	√	√	N/A	N/A
DEA Certificate (CA address, all schedules) (current at time of approval)	√	N/A	√	Not required	√	√	N/A	√	Optometrists (optional) — not all sched.	N/A
Hospital Admitting Privileges (PSV – current at time of approval)	√	N/A	√	Not required	N/A	N/A	N/A	√	N/A	N/A

(or admitting alternative plan)										
Medi-Cal enrollment/date (PSV)	√	√	√	N/A	√	√	√	√	√	√
Supervising MD / DOSA	N/A	N/A	N/A	N/A	√	√	N/A	√	N/A	N/A
Working locations / cred contact	√	√	√	√	√	√	√	√	√	√
OIG search (PSV w/in last 6 mos.)	√	√	√	√	√	√	√	√	√	√
NPDB search (PSV w/in last 6 mos.) CIN-BAD (DC's only)	√	CIN-BAD	√	√	√	√	√	√	N/A	N/A
Malpractice insurance (current at time of approval)	√	√	√	√	√	√	√	√	√	Liability
AMA/AOIA profile (initial MD/DO's)	√	N/A	√	√	N/A	N/A	N/A	N/A	N/A	N/A
Work history over last 5 years (explanation of gaps > 6 mos.)	√	√	√	√	√	√	√	√	N/A	N/A
Attestation / Release (w/in 1 year)	√	√	√	√	√	√	√	√	√	N/A
Quality Summary (FSR for all PCP's)	√	√	√	N/A	√	√	√	√	N/A	N/A

(Member grievances and peer review data for Recreds only)										

* Medical School/Residency information is verified once, at the time of initial credentialing.

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

It is necessary to have the provider's application, resume and/or curriculum vitae with a signed liability release dated within the past twelve (12) months to initiate a credentialing or recredentialing process.

C5: Facility Site, Medical Record and Physical Accessibility Reviews

CenCal Health conducts facility site reviews (FSRs), medical record reviews (MRRs), and physical accessibility reviews (PARs) for all PCPs as a requirement for participation in CenCal Health programs.

Reviews of sites for PCPs that serve SBHI and SLOHI members are conducted utilizing the DHCS Medi-Cal Managed Care Full Scope Site Review Survey and Medical Record Survey Tool. PCP sites must achieve a passing FSR score before members can be assigned to the respective PCPs. The FSR includes an on-site inspection and interview with the office personnel.

The MRR is based upon a survey of randomly selected medical records and is composed of pediatric and/or adult records, depending on the type of practice. The MRR review includes, but is not limited to, a review of format, legal documentation practices, documentary evidence of the provision of preventive care, and coordination of primary care services.

FSR and MRR audit tools are scored as per DHCS requirements, and corrective action plans (CAPs) are provided when needed. Critical element deficiencies always require a CAP. CAPs must be completed and verified within the timeframes dictated by DHCS. CenCal Health nurse reviewers who are certified by DHCS perform all FSR/MRR reviews and are available to help in completing CAPs.

After the successful completion of an initial full scope survey, the maximum time period before the next required full scope FSR/MRR is three years. CenCal Health may review sites more frequently, or when determined necessary based on prior findings.

PARS assessments enable CenCal Health to collect and publish information about the physical accessibility of a provider site for seniors and persons with disabilities

(SPDs), and they are performed on all PCP sites during the initial FSR. PARS are also performed on other provider sites such as specialists, ancillary, and CBAS providers that serve a high volume of SPDs. PARS assessments examine access to parking, the exterior building, elevators, interior building, exam rooms, and restrooms. The survey will also identify if an exam room has a height adjustable exam table and accessible weight scale for those with disabilities.

To download materials to prepare for a Facility Site Review/Medical Record Review, please visit the CenCal Health website at www.cencalhealth.org or email Provider Services for assistance at psrgroup@cencalhealth.org.

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

C6: Access to Care Standards

According to DHCS and the Medicaid Managed Care Final Rule: Network Adequacy Standards, CenCal Health is required to adopt access to care standards for its provider network. Please see the table below for a summary of the regulations. At least annually, we contact our providers to conduct appointment availability and after-hours access surveys. The survey format or methodology, as well as the provider types contacted, may change periodically based on DHCS direction. We appreciate the ongoing collaboration with our providers as we all strive toward the common goal of providing excellent care to the members we serve. Contact the Provider Services Department at (805) 562-1676 or email providerservices@cencalhealth.org for questions.

Appointment Time	Standard Time Frame
Non-urgent Primary Care Appointment	Within 10 business days to appointment from request
Non-urgent Specialty Appointment	Within 15 business days to appointment from request
Non-urgent OB/GYN Specialty Care Appointment	Within 15 business days to appointment from request
Non-urgent OB/GYN Primary Care Appointment	Within 10 business days to appointment from request
Non-urgent Mental Health (non-psychiatry) Outpatient Services Appointment	Within 10 business days to appointment from request
Non-urgent Ancillary Services Appointment (for diagnosis or treatment)	Within 15 business days to appointment from request

Urgent Care Appointment	Within 48 hours for services that do not require prior approval Within 96 hours for services that do require prior approval
Emergency Care	Immediately
+Primary Care Triage and Screening	Within 30 minutes
Mental Health Care Triage and Screening	Within 30 minutes
Wait Time in Office	Within 30 minutes
After Hours Care	24 hours a day
Telephone Access	24 hours a day

+ reflects "Triage" or "screening," and means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

C7: Terminating a Provider

In the event that a provider is terminated from the CenCal Health network, we must make every effort to ensure our obligations to the State and to our Members' care are met, including ensuring Members are notified and reassigned to another CenCal Health participating provider when appropriate.

As a Provider, it is important to ensure that you notify CenCal Health in writing at least 60 days prior to any changes to your practice that may result in terminating your Agreement with CenCal Health, examples include but are not limited to if you are moving, retiring, or resigning. CenCal Health is required to notify DHCS of Provider Termination as applicable to our contract.

Providers must also ensure that access to Members' records and other information necessary to ensure any needed coordination or transfer of care to another provider may occur, as required by your Agreement, and by State and other laws. Providers are obligated to cooperate and assist with ensuring our Members' needs are met during this time.

CenCal Health will acknowledge your written Notice of termination with a returned acknowledgement notice via email, and will also ask you to complete a Provider Exit Survey to gain valuable feedback and to identify opportunities for improvements to programs and services.

Section D: Provider Responsibilities

D1: Role of the Primary Care Provider (PCP)

The primary care provider (PCP) plays the central role in managing care for CenCal Health members, to assure quality of care in accordance with prevailing, evidence-based, medical standards. The PCP is the main provider of healthcare services for CenCal Health members and is responsible for the structuring and delivery of healthcare to his or her assigned members.

CenCal Health's model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services rendered by other physicians and/or providers to meet the member's healthcare needs.

D2: Responsibilities of the Primary Care Provider (PCP)

PCP responsibilities include, but are not limited to:

- Provide care for the majority of healthcare issues presented by the member, including preventive, acute, and chronic healthcare.
- Supply risk assessment, treatment planning, coordination of medically necessary services, referrals, follow up and monitoring of appropriate services, and resources required to meet the needs of the member.
- Case manage assigned members to ensure continuity of care, facilitate access to appropriate health services, reduce unnecessary referrals to specialists, minimize inappropriate use of the emergency department, maintain appropriate use of pharmacy benefits, and identify appropriate health education materials and interventions.
- Assure access to care 24 hours a day, seven days a week, including accommodations for urgent care, performance of procedures, and inpatient rounds.
- Coordinate and direct appropriate care for members, including:
    - Initial Health Assessments
    - Preventive services in accordance with established standards and periodicity schedules as required by age and according to the American Academy of Pediatrics (AAP) and the United States Preventive Services Task Force (USPSTF)
    - Second opinions
    - Consultation with referral specialists
    - Follow-up care to assess results of primary care treatment regimen and specialist recommendations
    - Special treatment within the framework of integrated, continuous care
    - Screen members for mental health and substance use difficulties, provide treatment within scope of practice, and assist the member with referrals to appropriate treatment providers.

- Coordinate the authorization of specialist and non-emergency hospital services for members.
- Contact and follow up with the member when the member misses or cancels an appointment.
- Record and document information in the member's medical record, including:

  - Member office visits, emergency visits and hospital admissions.
  - Problem lists, including allergies, medications, immunizations, surgeries, procedures, and visits.
  - Efforts to contact the member.
  - Treatment, referral, and consultation reports.
  - Lab and radiology results ordered by the PCP.
  - Authorization to Release Information to and from the member's mental health and substance use provider.
- Make reasonable attempts to communicate with the member in the member's preferred language, using available interpretation or translation services.
- If the member is currently receiving mental health or substance abuse treatment services, coordinate the member's care with the existing mental health or substance use provider.

D3: Service Obligations of Hospital for CenCal Health's Medi-Cal Members

Licensing

The Hospital shall be:

- Licensed as a general acute care hospital in accordance with the requirements of the California Health Facilities Licensure Act (Health and Safety Code, Sections 1250 and following) and the regulations thereunder
- Certified as a hospital provider by Medicare and Medi-Cal
- Accredited by JCAHO to provide Covered Services
- Equipped, staffed, and prepared to provide benefits to CenCal Health Members

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

Services Provided by Hospital

The Hospital shall provide benefits to Members, subject to the availability of appropriate facilities and services. Members are entitled to receive inpatient services when ordered by a Member's responsible physician or other qualified health practitioner, and said services should be provided in accordance with regulations as set forth in 22 CCR Section 51301. Services to be rendered are subject to exclusions, limitations, exceptions, and conditions as agreed to by the Hospital and CenCal Health.

Services Not Covered and Not Compensated

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

Services Rendered on Basis of Availability of Facility
The Hospital shall not discriminate against CenCal Health's Members in connection with its admission policies or practices. Admission of Members to the Hospital for care and treatment must be based upon the severity of medical need and the availability of Hospital facilities and Hospital services. The decision as to whether or not a Member requires specific medical care or hospital services is a professional medical decision to be made by the Member's attending physician in accordance with applicable medical staff rules and regulations.

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

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

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

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

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

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

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

Prescribed Drugs Under Emergency Circumstances

When the course of treatment provided to a Member under emergency circumstances requires the use of drugs, a sufficient quantity of drugs (including for the treatment of a mental health or substance use condition) shall be provided to the Member to last until he/she can reasonably be expected to have a prescription filled.

Discharge Summaries and Emergency Room/Urgent Care Center, or Treatment/Examining Room Reports

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

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

Miscellaneous Requirements

The Hospital agrees to:

- Verify a CenCal Health Member is eligible for benefits under the Program indicated on their identification card.
- Comply with the CenCal Health's Utilization Management Protocols.
- Use its best efforts to ensure that discharge planning is performed for all CenCal Health Members who are admitted to the Hospital in as expeditious and timely a manner as is possible, and to attempt to place these Members, who otherwise qualify for placement in skilled nursing facilities, in alternative non-institutional settings whenever possible.
- Permit the Member to be visited by his/her domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.
- Assure that domestic partners are treated on an equal basis with spouses, including coverage of dependents of domestic partners as with spouses.
- Work with CenCal Health to assure that Cultural and Linguistic needs of CenCal Health's members are met. Further information on Providing Culturally Competent Care, go to Section D, D7 in Member Services of this Provider Manual.

D4: PCP Requests for Member Reassignment

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. Outlined below is the procedure that should be followed when submitting a request.

- **Make Sure You Have an Appropriate Reason to Request Reassignment**

  APPROPRIATE Reasons to Request Reassignment of a Patient:
  - **Contractual**: Pediatric PCPs may request reassignment of a member who is beyond their scope of services, e.g., members who are beyond their contracted age limit or who become pregnant.
    Note: if maximum age limit is 16, the member cannot be removed from case management until the 17th birthday is reached. Typically, reassignments based on age happens automatically.
  - **Non-Contractual**: These reasons (listed below) often involve lack of cooperation on the part of the member, although in some instances the goal is to create the most beneficial relationship between member and provider. It is important that you supply sufficient information in the "Provider Remarks" section to enable us to determine if the request meets the criteria. Requests based on single or minor infractions will be denied. We also ask that you describe how you have attempted to correct the problem. **Requesting member reassignment should be the last resort!**
    - *Inappropriate Assignment by CenCal Health* - e.g., the member has re-linked to a provider who previously requested his reassignment to different providers.
    - *Member Drug Seeking* - specify how the behavior is manipulative in attempting to obtain substantially more medication than is warranted.

- *Member Circumventing Case Management/Demanding Referrals/Self Directing Care* - give examples that demonstrate a pattern.
- *Member Abusing ER Services* – this will only be approved for extraordinary cases of deliberate circumvention of case management and will require extensive documentation.
- *Language/Cultural Barriers*- this alerts CenCal Health that assignment to another provider (e.g., Spanish-speaking) may be more beneficial for the member. The member will be offered the choice of choosing a provider more familiar with his language/cultural needs.
- *Member "No Shows"* - list dates member no-showed for appointments without calling to cancel despite reminder calls/appointment verification (at least **3** separate dates in the **past year** to establish a pattern).
- *Member Non-Compliant with Treatment* - there must be potentially serious consequences due to non-compliance and a disregard for medical advice on the member's part.
- *Member Abusive/Threatening/Disruptive* - the member may just be disruptive, i.e. calling 20 times in one day for a non-urgent matter, or it may be more serious. Be specific with incidents/quotations. If the member poses an immediate threat to self or others, call the appropriate authorities!
- *Unable to Establish Interpersonal Relationship* - describe how a personality conflict or difference in belief systems significantly affects care.
- *Member Lying/Theft* - if the theft is of a serious nature (e.g., blank prescriptions) or there is an attempt of fraud, the appropriate authorities should be notified.

- **<u>INAPPROPRIATE reasons to request reassignment of a patient:</u>**
  - PCPs cannot request reassignment of patients simply because they are very sick and have a diagnosed condition that would be difficult to manage. It is vital that these patients have a "medical home" with a PCP to coordinate their care. To allow such shifting of patients is neither good medicine, nor is it in the best interests of any participating physician.
  - When a member moves to another area of the county and needs a PCP in closer proximity to his new home, the member must initiate a re-selection through a Member Services Representative. If you know a member has moved, please contact CenCal Health Member Services and be prepared to provide the member's new address or phone number.
  - A change to special class is needed:
    - for those members that move to a skilled nursing facility by the first day of the month and are expected to remain there for more than 30 days, for members that have moved out of

county, and for members with certain other circumstances, inform the Member Services department at (877) 814-1861.

If you would like assistance to determine if a particular situation meets the criteria for reassignment requests, or if you have questions about the process, please call provider services at (805) 562-1676.

- **Submitting a Reassignment Request via the CenCal Health Website**
  The PCP who wishes to request reassignment of a member under their case management should do so via the CenCal Health Provider Portal restricted site. You must have a valid username and password to access this feature; please follow the instructions for contacting the webmaster to obtain these if you have not done so already.

  - Select "PCP Reassignment Requests" from the list of forms. Enter your provider ID# (your NPI) and the member's Client ID# (CIN). 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 criteria are on this list.
  - You must enter supporting information in the "Provider Remarks" section, e.g., 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 Quality Liaison will pend the request and an email will be generated to you requesting additional information. Requests submitted on the 10th of one month through the 9th of the next month are processed by the cut-off date (9th day of each month at 4pm). An email will be generated to the PCP after the request has been processed to verify approval and the effective date. PCPs may also check the status of the request 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 after the 9th. 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 Department at (805) 562-1676 for further instructions.

D5: Medical Records

Each primary care office is responsible for maintaining adequate medical records of patient care. Records must be maintained in accordance with applicable federal and state privacy laws. All medical records must be maintained in a manner consistent with professional practices and prevailing community standards. Providers are required to maintain records for ten years after termination of agreement with CenCal Health, including the period required by the Knox-Keene Act and Regulations, and Medicare and Medi-Cal programs.
If an unauthorized disclosure of member information occurs, providers are to notify CenCal Health immediately upon discovery by calling CenCal Health's Toll-Free 24 Hour Compliance Hotline at (866) 775-3944.

Records Copying Surcharges

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

D6: Resources for Seniors and Persons with Disabilities

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

CenCal Health Services

- Non-Emergency and Non-Medical Transportation - CenCal Health contracts with:
    - Amwest Ambulance: (818) 859-7999
    - Ventura Transit System Inc.: (855) 659-4600

See "Non-Emergency Medical Transportation" in Section E, E9 for more information on this service.

- *Non-Medical Transportation* – Non-medical transportation services are provided as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service.
- *Interpreter Services* – telephonic, video when criteria is met and American Sign Language interpreter services.
- *Language Line Telephonic Services* - We also give providers 24/7 free access to Certified Languages International - for our members, which provides an interpreter by phone for over 140 languages. Instructions are in the Provider

Manual and on our website in the Language Assistance Program Resources Section N.
    - *Hearing Impaired* – can contact Member Services by using the California Relay Service at 711 or TTY (833) 556-2560.
- *Member Handbook* – available in large print and other formats upon request.
- *Information on wheelchair accessibility* and assistance with access issues.

Providers can reach a CenCal Health Member Services Representative by calling (877) 814-1861 option 3.
Education: Visit the Cultural Competency & Health Literacy page at CenCal Health's website for additional resources and learning opportunities to integrate into your practice.

Reference Link:
Cultural Competency & Health Literacy
www.cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-and-health-literacy/

D7: Providing Culturally Competent Care

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

What is Cultural Competence?
Cultural competence is the ability of healthcare providers and organizations to understand and respond effectively to the cultural and language needs of patients.

Cultural competence requires organizations and their personnel to:
- Value diversity
- Assess themselves
- Manage the dynamics of difference
- Acquire and institutionalize cultural knowledge
- Adapt to diversity and the cultural contexts of individuals and communities served

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

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

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

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

Gender/Sexuality Non-Discrimination: Providers should strive to normalize inclusion of all gender identities and sexual orientations within the practice setting, to create inclusive service delivery systems, and to use gender neutral language and labels. CenCal Health is required to treat members consistent with their gender identity. CenCal Health also provides transgender members with the same level of healthcare benefits that are available to non-transgender members, including all medically necessary services and/or reconstructive surgery.

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

Education: All CenCal Health contracted providers and training on the importance of Cultural Competency, Health Literacy, and Seniors and Persons with Disabilities (SPD). Please visit the Cultural & Linguistic Resources and Cultural Competency & Health Literacy website page at CenCal Health for additional resources and learning opportunities to integrate into your practice.

Reference Links:
Cultural & Linguistic Resources
www.cencalhealth.org/providers/cultural-linguistic-resources/

Cultural Competency & Health Literacy
www.cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-and-health-literacy/

Section E: Covered Benefits and Services

E1: Covered Services Overview

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

Eligibility

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

MEDI-CAL COVERED SERVICES ADMINISTERED BY CenCal Health Medi-Cal Covered Services administered by CenCal Health include, but are not limited to, the following:

- Physician services
- Hospital inpatient and outpatient services
- Whole Child Model (WCM) and California Children's Services (CCS)
- Emergency care services
- Health education programs
- Home healthcare
- Maternity care services
- Family planning
- Lab tests and X-rays
- Prenatal care
- Immunizations
- Durable medical equipment
- Medical supplies
- Prosthetics and orthotics
- Pediatric preventive services (CenCal Health CHDP Program)
- Immunizations
- Physician Administered Prescription drugs
- Transportation — emergency
- Transportation — non-emergency medical transportation services
- Hospice
- Long-term care and skilled nursing care services
- Physical therapy/occupational therapy
- Vision services
- Mental health services
- Behavioral Health Treatment (BHT)
- Palliative Care

MEDI-CAL COVERED SERVICES NOT ADMINISTERED BY CenCal Health
CenCal Health does not administer certain Medi-Cal covered services. The following identifies these covered services, as well as where to obtain more information in this provider manual about referrals for these services:

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

Reference Link:
DHCS Medi-Cal Providers
https://www.medi-cal.ca.gov/

E2.1: Acupuncture Services

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

Types of Services Provided

SBHI & SLOHI Members – The following Acupuncture Services are Covered Benefits for Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) members:

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

Authorizations

Acupuncture services are subject to the two-services per month Medi-Reservation limitation. A Medi-Reservation must be made by the Acupuncturist for each visit provided. Services may be reserved by completing and submitting the Medi-Reservation Form found on CenCal Health's website, https://www.cencalhealth.org/. A confirmation number will be given once the Service is reserved. For more information on Medi-Reservations please refer to Section H, H5 of the Provider Manual.

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

E2.2: Audiology Services

CenCal Health Members may access Audiological Services - to determine hearing loss and evaluate the need for a Hearing Aid. Access to Hearing Aids includes both the instrument, and the fitting of the Hearing Aid, education, adjustments and repairs as indicated below.

"Audiologist" shall mean a person who performs procedures of measurement, appraisal, identification and counseling related to hearing and disorders of hearing; provides rehabilitation services for the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and recommends and evaluates Hearing Aids. An audiologist shall be licensed by the Speech Pathology and Audiology Examining Committee of the State Board of

Medical Quality Assurance or similarly licensed by a comparable agency in the State in which he/she practices.

"Audiological Services" shall mean services for the measurement, appraisal, identification, and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior, and the recommendation and evaluation of Hearing Aids.

"Hearing Aid" shall mean any aid prescribed for the purpose of aiding or compensating for impaired human hearing loss.

Type of Services
Audiological Services provided, by acting within the scope of their practice as authorized by California law, are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI).

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

Covered Audiology and Hearing Aids Benefits for SBHI & SLOHI Members
Audiological Services for SBHI & SLOHI Members are considered Limited Services. One initial or first visit may be allowed for each Member in a six-month period for each Provider, and it is included in the two services per month limitation that applies to all Limited-Service Providers. This initial visit, which does not require prior authorization from the Primary Care Physician (PCP) or Attending Physician, should be billed with HCPCS Code X4502.

Authorizations
Referrals and prior authorizations are not required for a member to access Audiology services. A Medi-Reservation must be made by the Audiologist for each visit

provided. Authorization will not be granted to extend Audiology services beyond the services reserved through a Medi-Reservation. Services may be reserved by completing and submitting the Medi-Reservation Form found on CenCal Health's website, https://www.cencalhealth.org/. A confirmation number will be given once the Service is reserved. For more information on Medi-Reservations please refer to Section H, H5 of the Provider Manual.

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

E2.3: Chiropractic Services

Type of Services Provided
Services provided by Chiropractor providers are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI). A member may access Chiropractic services for treatment of the spine and neck by means of manipulation.

Covered Chiropractor Services for SBHI and SLOHI
SBHI & SLOHI Member Benefit Restriction
Chiropractic services are a restricted benefit for SBHI and SLOHI Members. The following chiropractic services are covered benefits for Members and services meeting the criteria listed below for SBHI & SLOHI Members. Two visits per month total.

- Services rendered by a Chiropractor who is enrolled in the Medi-Cal program, eligible to provide Medi-Cal services, and contracted with CenCal Health as a provider.
  SBHI and SLOHI – The following chiropractic services are covered benefits for SBHI & SLOHI.
- Services limited to the treatment of the spine rendered by a licensed Chiropractor.
- Members 20 years old and under
- Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the nursing facility to be covered. Members can be identified by an Aid Code of 13, 23, 53 or 63 when checking eligibility
- Rendered by a Federally Qualified Health Center (FQHC)

Authorizations
Referrals and prior authorizations are not required for a member to access Chiropractic services. A Medi-Reservation must be made by the Chiropractor each visit provided. Services may be reserved by completing and submitting the Medi-Reservation Form found on CenCal Health's website, www.cencalhealth.org. A confirmation number will be given once the Service is reserved. For more

information on Medi-Reservations please refer to Section H, H5 of the Provider Manual.

Should a Chiropractor feel that x-rays are necessary, he/she should contact the Member's PCP or attending physician and discuss the need for these diagnostic services. The PCP or attending physician may authorize said services to a contracted radiology or X-Ray provider.

E2.4: Hearing Aids Services

Services provided by Hearing Aid providers are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI).

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

Covered Hearing Aid Services for SBHI, SLOHI

CenCal Health covers hearing aids when supplied by a hearing aid dispenser on the prescription of an otolaryngologist, or the attending physician. An audiological evaluation, including a hearing aid evaluation performed by, or under the supervision of, the above prescribing physician, or by a licensed audiologist, is required.

The following procedures are Covered Benefits as indicated below:

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

Non-Covered Charges for SBHI, SLOHI

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

Authorizations

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

E2.5: Home Health Services

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

Covered Services

SBHI, SLOHI, Members – The following Home Health services are Covered Benefits for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI), members:

- Diagnostic and treatment services that can reasonably be provided within the home.
- Nursing care provided by a registered or licensed vocational nurse, or a licensed home health aide who is working in conjunction with a registered or licensed vocational nurse.
- Rehabilitation and/or, physical, occupational, or speech therapy, as determined by the physician to be medically necessary.
- Medical supplies if they are given by approved Providers and are in accordance with the Member's written treatment plan.
- The use of medical appliances if it is in accordance with the Member's written treatment plan.

Authorizations

Prior authorization is required for services beyond case evaluation. Certain services performed in conjunction with the initial case evaluation is exempt from this requirement. Please refer to the Medi-Cal manual for exemptions at Medi-Cal: Provider Manuals. Authorization request must include a written treatment plan attached to a Treatment Authorization Request form (TAR). TAR's must include the CPT code. Please refer to the Authorization Section H, H4 for further instructions.

E2.6: Hospice Services

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

Covered Services

SBHI and SLOHI – The following Hospice services are Covered Benefits for Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative:

- Services connected to the medical management of the pain and symptoms associated with a terminal illness and its related conditions.
- Skilled nursing services, certified health aide services, and homemaker services under the supervision of a qualified registered nurse.
- Physician services.
- Physical, occupational, and speech therapy services, for the purpose of symptom control, or to enable members to maintain activities of daily living and basic functional skills.
- Short-term inpatient care arrangements related to the terminal illness.

- Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the management of the terminal illness and related conditions.

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

- Hospital, Nursing Facility (Level A & B), and Home Health Agency care.
- Medical equipment and supplies, and pharmaceuticals.
- Medical transportation.

Authorization – Providers must obtain a pre-authorization for all levels of hospice care via an approved Treatment Authorization request (TAR) for CenCal Health members.

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

E2.7: Incontinence Supplies

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

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

Prescription

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

- The prescription is only valid for a six (6) month period, and it must be renewed every six (6) months for updated medical justification.
- The member's physician (Primary Care Physician or attending physician) must write individual prescriptions prior to the delivery of service, ordering only those supplies necessary for the care of that member.

- The physician's medical record must show each prescription with the anticipated rate of use for that specific item as well as the specific causal diagnosis and the type of incontinence for which the incontinence supplies were prescribed.

- A copy of the current prescription must be retained in the member's medical chart.

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

Affected supplies under the cost limitation include disposable briefs (diapers), protective underwear (pull on products), underpads, belted undergarments, shields, liners, pads and reusable underwear. The procedure codes listed in the Medi-Cal Manual at Medi-Cal: Part 2 – Durable Medical Equipment and Medical Supplies (DME) are under the monthly dollar threshold of $200 and have their quantity limitation waived up to the $200 threshold.

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

In addition, the following members are covered By CenCal Health.
- Members 20 years old and under.
- Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the nursing facility to be covered. Members are identified by an Aid Code of 13, 23, 53 or 63 in the Eligibility Screen.

Authorizations
Prior authorization is required for services, please reference Section H, H20 for additional verify authorization requirements.

E2.8: Laboratory Services

Covered Services
Services provided by Laboratory providers, acting within the scope of their practice as authorized by California law, are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI) - include the biological, microbiological, serological, chemical, immunohematology, hematological, biophysical, cytological, pathological, or other types of examination of materials

derived from the human body, for purposes of diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

Covered Laboratory Benefits

- Maternity Care: laboratory testing, includes genetic and alpha-fetoprotein testing.
- Outpatient hospital and other outpatient facilities: Diagnostic services includes laboratory services.
- Inpatient hospital services: include laboratory services.
- Diabetes management and treatment includes outpatient services and laboratory testing.
- For SBHI including at a minimum: Cholesterol, triglycerides, microalbuminuria, HD/LDL, and Hemoglobin A-1C (Glycohemoglobin).
- Testing to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications

Access

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

Authorizations

Prior authorization is required for services. To verify authorization requirements please refer to Section H.

Specific Authorization of Laboratory Services

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

E2.9: Lactation Services

Covered Services:

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

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

Authorizations

Prior authorization is required for services; please verify authorization requirements in Section H of the Provider Manual

E2.10: Nursing Facility

Covered Services:

Provider is a Nursing Facility, also known as a Skilled Nursing Facility or Long-Term Care facility. Provider shall adhere to the rules and regulations pursuant to the California Health Facilities Licensure Act, and to the rules and regulations of the Medi-Cal and Medicare programs. Nursing Facility represents and warrants that it is currently and for the duration of this Agreement shall remain certified under Title 18 of the Federal Social Security Act. Nursing facilities that serve members for a primary psychiatric disorder are not covered by CenCal Health, but by the local County Mental Health Plan.

DEFINITIONS

"Day" or "Days" means calendar days, unless otherwise noted.

"Facility Services" includes, but is not limited to, the following services when ordered by a Member's responsible physician or other qualified health practitioner and rendered to Members in accordance with the W&I Codes, applicable sections of 22 CCR for Skilled Nursing Facilities and intermediate care facilities, subject to any exclusions, limitation, exceptions, and conditions as may be set forth in the Agreement.

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

"Nursing Facility" means a facility that is licensed as either a Skilled Nursing Facility or an Intermediate Care Facility.

"Skilled Nursing Facility" means any institution, place, building, or agency which is licensed as a Skilled Nursing Facility by DHCS or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR § 51215 (except that the distinct part of a hospital does not need to be licensed as a Skilled Nursing

Facility) and has been certified by DHCS for participation as a Skilled Nursing Facility in the Medi-Cal program. The term "Skilled Nursing Facility" shall include the terms "skilled nursing home", "convalescent hospital", "nursing home", or "Nursing Facility".

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

SERVICES

Coverage shall be provided in accordance with the standards set forth in 22 CCR § 51335 and any or all Attachments to Exhibit A and in the Member's EOC.

ACCESS
Nursing Facility shall provide Medi-Cal Facility Services to Members, subject to the availability of appropriate skilled nursing care services and/or intermediate care services. Nursing Facility shall additionally adhere to the provisions of the State Long Term Care Manual.

Authorizations – Please refer to Section H of the Provider Manual

E2.11: Nutrition Educators

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

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

Under the benefit, members are entitled to an initial assessment not to exceed 4 hours per year; a re-assessment and intervention not to exceed 4 hours per 1 month; and group sessions not to exceed 8 hours per a 9-month period. Re-assessments and additional services beyond these benefit limitations require prior authorization (these limits do not apply to children under 21 due to EPSDT regulations). Members under the age of 21 do not have treatment limits apart from medical necessity criteria.

Authorizations - Please refer to the Referral Authorization Process section on the CenCal Health website and reference the RAF Exceptions List for information on services that do not require a RAF, and Section H of the Provider Manual for general authorization requirements.

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

Reference Link:
RAF Exceptions List
cencalhealth.org/providers/authorizations/referrals/

E2.12: Optician Services

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

Type of Services provided by dispensing opticians, acting within the scope of their practice as authorized by California law, are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI) and Prenatal Plus 2 (PP2) members include filling prescriptions of physicians for prescription lenses and related products, fitting and adjusting such lenses and spectacle frames. A dispensing optician is also authorized to act on the advice, direction and responsibility of a physician or optometrist in connection with the fitting of a contact lens or contact lenses. A dispensing optician may also be referred to as Optician.

Covered Services:

- Members 20 years old and under.
- Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the nursing facility to be covered. Members are identified by an Aid Code of 13, 23, 53 or 63 when checking eligibility.
- Eyeglasses, when necessary and prescribed.
- Contact lenses, when medically necessary and prescribed.
- Visits for fitting glasses and contact lenses.

E2.13: Optometry Services

Covered Services:
Optometry and Optician Service for SBHI and SLOHI Members include an eye examination every two (2) years. Eyeglasses are a covered benefit every two (2) years for Members who are exempt from the optional benefit elimination. A referral from the Member's PCP is not necessary.

Members in the following category are eligible for eyeglasses, eye appliances and related services in addition to optometry services.

- Members 20 years old and under.
- Members residing in a skilled nursing facility, i.e., Nursing Facilities Level A [NF-A] and Level B [NF-B]) or intermediate care facility for the developmentally disabled (ICF-DD or ICF-DDH). Services do not need to be physically provided in the nursing facility to be covered. Members are identified by an Aid Code of 13, 23, 53 or 63 when checking eligibility.

Authorizations
Prior authorization is required for services, please refer to Section H for authorization guidelines.

E2.14: Vision Services

Covered Services:
One routine eye exam with refraction every 24 months, with a second eye exam with refraction when medically necessary.
Eye appliances when prescribed by a physician or optometrist, including prescription eyeglasses, eyeglass frames, contact lenses (when medically necessary), low vision aids (excluding electronic devices) and prosthetic eyes.

CenCal Health covers optometry services for the following types of Medi-Cal members:

- Members who have full-scope Medi-Cal benefits and who are under age 21.
- Members who are residents of a Nursing Facility.
- Members whose course of treatment began prior to July 1, 2009, and continues after July 1, 2009.
    - Members receiving services due to a condition that might complicate a pregnancy.
    - Members receiving optometry services in a hospital outpatient department.

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

E2.15: Physical Therapy Services

Covered Services:
A Member may access Physical Therapy services (PT) when treatment is prescribed by a physician to restore or improve a person's ability to undertake activities of daily living when those skills are impaired by developmental or psycho-social disabilities, physical illness or advanced age.

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

Covered PT Benefits for SBHI, SLOHI
The following procedures are Covered Benefits:

- PT services are a covered benefit only when services are provided pursuant to a written prescription of a CenCal Health physician or podiatrist, which is within the scope of their medical practice.
- PT services are only covered when care is rendered in the Provider's office or in an outpatient department of a hospital facility.
- PT services must be performed by licensed and registered therapists.
- PT services are also covered when the Member is an inpatient at an acute care hospital, in a skilled nursing facility, or at home.

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

Authorizations

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

E2.16: Emergency Medical Transportation Services

Covered Services:

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

Types of Services Provided

SBHI and SLOHI Members The following Emergency Medical Transportation Services are Covered Benefits for Santa Barbara Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) members:

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

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

transportation provider number, and the transport meets one of the following conditions:

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

Non-Covered Services

SBHI and SLOHI Members – The following Emergency Medical Transportation Services are Non-Covered Benefits for SBHI and SLOHI members:

- Transportation services other than those specifically provided for in the provider's agreement and in the member's Evidence of Coverage, including but not limited to passenger car, taxi, or other form of public or private conveyance.
- Services outside the scope of an Emergency Medical Transportation Provider as set forth in the EDS Medi-Cal Provider Manual.

SLOHI Members under the age of 21 and Hospital to Hospital transports - Provider must submit an attachment to the claim that supports that an emergency existed. The statement must include the following:

- The name of the person or agency that requested the service.
- The nature of the emergency.
- The name of the hospital the member was transported to.
- Clinical information on the member's condition.
- The reason emergency transportation was considered medically necessary.
- The name of the physician that accepted responsibility for the member.

Authorizations

Please refer to Section H, H4 of the Provider Manual.

E2.17: Durable Medical Equipment

DME providers will be responsible for first determining the eligibility of members to receive services, for meeting the elements of and documenting services as indicated below, and in order to receive payment, for submitting claim forms to CenCal Health.

Type of Durable Medical Equipment (DME) Services Provided

Services provided by DME providers, acting within the scope of their practice as authorized by California law, are covered for Santa Barbara Health Initiative (SBHI), and San Luis Obispo Health Initiative (SLOHI) members.

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

- Can withstand repeated use.

- Is used to serve a medical purpose.
- Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly.
- Is appropriate for use in or out of the member's home.

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

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

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

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

Non-Covered Charges of DME

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

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

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

Additional authorization for DME products

- Prior Authorization, in the form of a **Treatment Authorization Request (TAR)** for SBHI and SLOHI is required for the purchase, repair or maintenance, or cumulative rental of DME subject to the conditions, restrictions and exceptions as specified below:
    - **Purchases** exceeding $100.00 (cumulative within a calendar month)
    - **Rentals** exceeding $50.00 (cumulative with a 15-month period)
    - **Repairs or maintenance** exceeding $250.00 (cumulative within a calendar month)
    - Purchase, rental or repair of **any miscellaneous item** over $50.00
- Prior Authorization is also required for the provision of oxygen when more than 500 cubic feet is provided during one calendar month.
- Purchase, rental, repair or maintenance of unlisted devices or equipment may require Authorization as set forth in CenCal Health regulations.
- Authorization shall not be granted for DME when a household item will adequately serve the member's medical needs.
- Authorization for DME shall be limited to the lowest cost item that meets the member's medical needs.
- Authorization for customized DME for transitional inpatient care members, skilled nursing facility or intermediate care facility inpatients may be approved if it meets applicable regulatory provisions.

E2.18: Medical Supplies

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

If providing incontinence supplies, please refer to the Protocols for Incontinence Supplies in Section E, E2.7.

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

- The prescription is only valid for a six (6) month period, and it must be renewed every six (6) months for updated medical justification.

- The member's physician (Primary Care Physician or attending physician) must write individual prescriptions prior to the delivery of service, ordering only those supplies necessary for the care of that member.
- The physician's medical record must show each prescription with the anticipated rate of use for that specific item.
- A copy of the current prescription must accompany all authorization requests.

Limitations
Medical Supplies have a quantity per period threshold. Please refer to the Medi-Cal Manual, located at https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx to determine the quantity allowed per timeframe.

Exceeding the quantity threshold as set forth in the Medi-Cal Manual requires approval through a Treatment Authorization Request (TAR) for members of the Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI).

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

The maximum timeframe for a medical supply authorization is six (6) months. All TARs/ARs require documentation of medical necessity as defined below:

- Request only those items that will exceed the quantity threshold.
- From and through dates not to exceed a six (6) month timeframe.
- The primary ICD-10-CM code should be entered in the diagnosis field.
- For requests over the quantity limitations, please provide, in addition to the prescription, written medical justification explaining why the member needs supplies in excess of the thresholds set by Medi-Cal. This description should be in a narrative format. The provider should inform the ordering physician of quantity limitations so that medical justification can properly address the specific condition of the member.
- Enter Units of Service and Quantity fields as indicated below.

Units vs. Quantity
The Units of Service field on a TAR represents the number of months for which the item is being requested to not exceed six (6) months. The Quantity field on a TAR represents the number of items being provided each month. Please do not calculate the total items being requested on the TAR for the entire timeframe; that calculation will be handled internally upon the plan processing the authorization.

- If submitting authorization through CenCal Health's website, please ensure that the documentation required for the authorization is faxed to the plan on the same day as the submittal of the web TAR. Please add the TAR number to each page of the documentation to ensure the information being faxed is attached to the correct authorization. Paper authorization

forms should be mailed or faxed with all supporting documentation included.

- If there is a delay in providing the required documentation, please notify the Health Services Department at (805) 562-1082 or directly to the plan staff member requesting the additional documentation needed to process the authorization.
- Email is the most effective means of communication for authorizations; if you are not already receiving email notifications for authorization submission or if you need to update your email address, please contact the Provider Services Department at (805) 562-1676 or submit these details in writing via email at providerservices@cencalhealth.org

E2.19: Occupational Therapy

Type of Services Provided

CenCal Health covers occupational therapy services when ordered on the written prescription of a physician, dentist or podiatrist and rendered by a CenCal provider.

Prescription Requirements

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

- Signature of the prescribing practitioner
- Name, address, and telephone number of the prescribing practitioner
- Date of prescription
- Medical condition necessitating the service(s) (diagnosis)
- Supplemental summary of the medical condition or functional limitations must be attached to the prescription
- Specific services (for example, evaluation, treatments, modalities) prescribed
- Frequency of services
- Duration of medical necessity of services-Specific dates and length of treatment should be identified if possible. Duration of therapy should be set by the prescriber; however, prescriptions are limited to six months.
- Anticipated medical outcome as a result of the therapy (therapeutic goals)
- Date of progress review (when applicable)
- Age
- Functional limitations
- Mental status and ability to comprehend
- Related medical conditions
- Delay in achievement of developmental milestones in a child or impairment of normal achievement in an adult.

Eligibility

Occupational Therapy providers must confirm that the member presenting in his/her office is eligible for services under CenCal Health.

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

Documentation of Services

The Occupational Therapy provider shall document services by completing a claim form and submitting the form to CenCal Health.

Authorizations

Occupational Therapy providers are required to obtain a prescription from the member's Physician, dentist or pediatrist. Referral Authorization Forms (RAFs) are not required for services under any program.

Nursing Facility Prior Authorization Requirements

Occupational therapy services rendered to NF-A or NF-B recipients require prior authorization. A TAR must be submitted for services that are not included in the per diem rate for a Nursing Facility.

Authorization approval is limited to services that:

- Are necessary to prevent or substantially reduce an anticipated hospital stay
- Continue a plan of treatment initiated in the hospital
- Are recognized as a logical component of post hospital care

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

• Limitation of two services per month does not apply.

• Initial and six-month evaluations do not require prior authorization. For billing instructions, refer to "Initial and Six-Month Evaluations" in this section.

• Authorization is required for any additional occupational therapy service beyond the initial and six-month evaluation.

Please refer to the TAR/AR Sections of this Provider Manual for more information.

Billing for Covered Services

Occupation Therapy Services:

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

Procedure Codes

Initial and Six-Month Evaluations

Initial and six-month evaluations billed under HCPCS code H4108 do not required prior authorization.

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

E2.20: Orthotics and Prosthetics

Orthotic and Prosthetic providers will be responsible for first determining the eligibility of members to receive services, for meeting the elements of and documenting services as indicated below, and to receive payment, for submitting claim forms to CenCal Health.

"Orthotist" shall mean a person who makes and fits orthopedic braces for the support of weakened body parts or the correction of body defects.

"Prosthetic and Orthotic Appliances" shall mean those appliances prescribed by a physician, dentist or podiatrist for the restoration of function or replacement of body parts.

"Prosthetist" shall mean a person who makes and fits artificial limbs or other parts of the body.

Eligibility

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

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

Orthotics & Prosthetics Benefit

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

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

Non-Covered Items of Orthotics and Prosthetics

- Corrective shoes, shoes inserts and arch supports except for therapeutic footwear and inserts for individuals with diabetes
- Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts
- Dental appliances
- Electronic voice producing machines
- More than one device for the same part of the body

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

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

Additional authorization for DME products
Prior Authorization, in the form of a **Treatment Authorization Request (TAR)** for SBHI and SLOHI is required for the following conditions:

- **Orthotics** exceeding $250.00 (cumulative in a 90-day period)
- **Prosthetics** exceeding $500.00 (cumulative in a 90-day period)

Billing for Covered Services
Orthotic and Prosthetic providers bill CenCal Health, using provider's Medi-Cal provider number for SBHI and SLOHI for the Orthotic and Prosthetic services he/she has provided to the eligible member. In the event the member has other coverage, or third-party liability is involved, the DME provider shall follow the terms and conditions of his/her Agreement with CenCal Health, or as indicated in "Other Health Coverage" in the Claims Section of this Provider Manual.

Co-payments
No co-payments for Orthotics and Prosthetics are required for the following programs: SBHI or SLOHI; however, the IHSS program requires co-payments in the form of co-insurance.

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

E2.21: Speech Therapy

Type of Services Provided
CenCal Health covers speech therapy services when ordered on the written prescription of a physician or dentist and rendered by a CenCal provider.

Speech Therapy Benefits for Members under the age of 21

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

Eligibility

Speech Therapy providers must confirm that the Member presenting in his/her office is eligible for services under CenCal Health

Medi-Services

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

Authorizations

Speech Therapy providers are required to obtain a prescription from the Member's physician or dentist **Prescription Requirements:**

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

- Signature of the prescribing practitioner
- Name, address, and telephone number of the prescribing practitioner
- Date of referral
- Medical condition necessitating the service(s) (diagnosis)
- Supplemental summary of the medical condition or functional limitations
- Specific services (for example, evaluation, treatments, modalities) prescribed
- Frequency of services
- Duration of medical necessity for services – specific dates and length of treatment should be identified if possible. Duration of therapy should be set by prescriber
- Anticipated medical outcome because of the therapy (therapeutic goals)
- Date of progress review (when applicable)

Recipient Information

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

- Age
- Developmental status and rate of achievement of developmental milestones
- Mental status and ability to comprehend

- Related medical conditions
  The goal of therapy should be achievement of intelligibility rather than age-specific qualities or previous condition status, such as with a stroke victim.

Certified Rehabilitation Centers and Nursing Facilities

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

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

Billing for Covered Services

Speech Therapy Services:

- Speech Therapy providers shall bill using Provider's valid billing number
- The ICD-10- diagnosis code(s), or appropriate successor code set, of the member's condition must be on the claim
- If member's condition is related to employment, then CMS-1500 box 10a must be checked "YES".
- box 10b must be checked "YES"

Speech Generating Devices (SGDs)

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

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

The rental of an SGD will only be allowed if the Member's SGD is being repaired or modified, or if the Member is undergoing a limited trial period to determine appropriateness and ability to use the SGD. Purchase of an SGD must be billed with modifier NU and the rental of an SGD must be billed with modifier RR. A repair of an SGD should be billed with the appropriate SGD HCPCS code for the part repaired followed with modifier RP.

Authorization of the SGD

An Authorization Request requires all the following documentation:

Recipient Assessment

- medical diagnosis and significant medical history,
- visual, hearing, tactile and receptive communication impairments or disabilities, and their impact on the recipient's expressive communication, including speech and language skills and prognosis,
- current communication abilities, behaviors and skills, and the limitations that interfere with meaningful participation in current and projected daily activities,
- motor status, optimal positioning, and access methods and options, if any, for integration of mobility with the SGD,
- current communication needs and projected communication needs within the next two years,

- communication environments and constraints that impact SGD selection and features,
- any previous treatments of communication problems, responses to treatment, and any previous use of communication devices,

Summary of Requested SGD

- vocabulary requirements,
- representational systems,
- display organization and features,
- rate of enhancement techniques,
- message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory visual output, programmability, input modes and their appropriateness for use by the specific recipient,
- portability and durability, and adaptability to meet anticipated needs,
- identity, significant characteristics, and features,
- manufacturer's catalog pages, including cost (for "By Report" SGDs),
- any trial period when the recipient used the recommended device(s) in an appropriate home and community-based setting that demonstrated the recipient is able and willing to use the device effectively,
- an explanation of why the requested device(s) and services are the most effective and least costly alternative available to treat the recipient's communication limitations,
- whether rental or purchase of the device is the most cost-effective option, vendors,
- warranty and maintenance provisions available for the device(s) and services

Treatment Plan

- the expected amount of time the device will be needed, and the amount, duration and scope of any related services requested to enable the recipient to effectively use the device to meet basic communication needs,
- short-term communication goals,
- long-term communication goals,
- criteria to be used to measure the recipient's progress toward meeting both short-term and long-term goals,
- identification of the services and providers (and their expertise and experience in rendering these services)

Claim Information

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

E2: Limited Services

Limited Services are restricted benefits for SBHI and SLOHI members. Limited Service for adult members include, but are not limited to Acupuncture, Audiology and

Chiropractic Services, which are subject to a maximum of two services per month or combination of two (2) services per month.

Physical Therapy Services are allowed up to a maximum of eighteen (18) services per year without an authorization. Additional services may be provided based upon medical necessity through the TAR process. For further instructions on TAR's, please reference Authorization Section H of the this Provider Manual for more details.

Eligibility

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

Billing for Covered Services

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

Authorizations:

"Medi-Reservation" shall mean a method a specific provider of limiting/reserving the Medi-Services (or "Limited Services") allowed under the Medi-Cal program, whereby a Member is entitled only to two visits or services per month. Please refer to Section H of the Provider Manual.

E3: Adult Preventive Services

CenCal Health promotes all preventive health services for adults in accordance with the most recent United States Preventive Services Task Force (USPSTF) "Guide to Clinical Preventive Services." Additionally, CenCal Health promotes immunization recommendations for adult Members in accordance with the most recent Centers for Disease Control and Prevention (CDC) "Recommended Immunization Schedule for Adults aged 19 Years or Older." CenCal Health requires Primary Care Physicians or Advanced Practice Providers to make available this core set of preventive services consistent with the USPSTF and CDC. Copies of these guidelines are available from CenCal Health upon request. Both documents are on CenCal Health's Preventive Health Guidelines website page.

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

- Immunizations
- Screenings for hypertension, cholesterol, depression, tobacco cessation, substance use and cancer screenings
- Laboratory tests
- Adverse Childhood Experiences (ACE) Screening (new 2020)

Assessment of medically necessary preventive services may be done at any opportunity, but at least annually during Initial and Periodic Preventive Medicine Evaluation visits. Preventive Medicine Evaluations are CenCal Health benefits and

are paid on a fee-for-service basis. Reimbursement rates for Preventive Medicine Evaluations are set forth in the Agreement in Exhibit A, Section 5.6. CPT codes for these Preventive Medicine Evaluation visits are: 99385-99387 for new patients, and 99395-99397 for established patients. Most routine screenings performed by primary care practitioners (i.e. visual acuity screening) are included in the Preventive Medicine Evaluation exam and are not separately billable. If uncertain, to verify whether a particular screening test is separately billable, please contact your CenCal Health Claims Representative.

CenCal Health updates and publishes the Preventive Health Guidelines (PHG) annually in the *Your Health/Su Salud* member newsletter. CenCal Health's Member Services Department sends the PHG documents to new members and conducts outreach to adult Members due for a preventive healthcare visit.

New Members are also encouraged to make an appointment for a Preventive Medicine Evaluation, otherwise known as an Initial Health Assessment (IHA) within 120 days of enrollment. For adult Members, the IHA follows the requirements of the Health and Safety Code, Sections 124025, and following, and Title 17, CCR, Section 6842 through 6852.

Reference Link:
CenCal Health Preventative Health Guidelines For Adults (English/Spanish Handout)
cencalhealth.org/providers/care-guidelines/preventive-health-guidelines/

Centers for Disease Control and Prevention (CDC) Immunization Schedule for Adults aged 19 Years or Older
www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf

CenCal Health Quality of Care
https://www.cencalhealth.org/providers/quality-of-care/

CenCal Health Preventative Health Guidelines
https://www.cencalhealth.org/providers/care-guidelines/preventive-health-guidelines/

E4: Pediatric Preventive Services

CenCal Health promotes all preventive health services for children in accordance with the most recent American Academy of Pediatrics (AAP) "Recommendations for Pediatric Preventive Health Care (Periodicity PDF). Immunization recommendations for all Members are in accordance with the most recent "Recommended Immunization Schedule for Children and Adolescents" approved by the Advisory Committee on Immunization Practices (ACIP). Both documents are on CenCal Health's website at https://www.cencalhealth.org/providers/care-guidelines/preventive-health-guidelines/

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

- Health and developmental history, including assessment of both physical and mental health development
- Physical examination

- Oral health assessment (dental screening) and referral; including fluoride varnish application in PCP office
- Health education and anticipatory guidance appropriate to age, including but not limited to counseling about nutrition and physical activity and assessment/discussion of BMI percentile
- Screenings appropriate to age, including but not limited to tests for vision, hearing, dyslipidemia, depression, and adverse childhood experiences.
- Completion and review of a Staying Healthy Assessment (SHA)
- Immunizations
- Laboratory tests, including but not limited to tests for anemia, diabetes, lead exposure, tuberculosis, and urinary tract infections

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

New Members are also encouraged to make an appointment for a Preventive Medicine Evaluation, otherwise known as an Initial Health Assessment (IHA) within 120 days of enrollment. For more information about IHAs, refer to section L7: Initial Health Assessments of the manual.

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

E5: Child Health and Disability Prevention (CHDP) Program

Child Health and Disability Prevention (CHDP) program is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP administers the federally mandated "California's version of the Federal Early Periodic Screening, Diagnosis and Treatment (EPSDT)" benefit of the Medi-Cal program for individuals under the age of 21.

The County CHDP program covers members from birth up to 21 years of age who are enrolled in the Medi-Cal Gateway program or have no health coverage.

CenCal Health is directly responsible for paying providers for Medi-Cal services covered under federally mandated EPSDT services not already paid for through the CHDP program for CenCal Health members.

All billing for CHDP services, is to be billed directly to CenCal Health for CenCal Health members. Claims submitted by a provider who is not contracted with CenCal Health will be denied payment for the CHDP services provided. We encourage providers to initiate a contractual relationship with CenCal Health. If you have any questions, please call CenCal Health Provider Services Line at (805) 562-1676.

Provider Participation Requirements

Although the CHDP program is administered by the County Children's Medical Services Department and is separate from CenCal Health, CenCal Health Primary Care Providers who see CHDP eligible members are encouraged to consider participating in this program. Members with suspected problems are referred for necessary diagnosis and treatment. The earlier they are identified, the faster they can be treated and more serious problems can be prevented. It is important to note that CHDP providers are reimbursed for the exams in addition to the monthly capitation the PCP receives from CenCal Health.

The PCP is responsible for the primary care case management, coordination of medical referrals, and the continuity of care for members qualified to receive CHDP services.

PCP is also responsible for the following activities:

- Assist with scheduling medical appointments.
- Following up on missed appointments,
- Referring children to the County CHDP Program who have lost Medi-Cal eligibility and CenCal Health benefits but who still require treatment.
- CHDP services provided by a provider other than the assigned PCP will require a RAF for payment.
- Referring members who are potentially eligible for community resources to such local resources.
- Referring children with a possible mental health diagnosis (excluding Autism Spectrum Disorder) to County Mental Health for assessment and treatment services under EPSDT regulations.
- Referring children with developmental delays for assessment and treatment services under EPSDT regulations. Referrals may include an evaluation to a licensed psychologist for evaluation of a possible diagnosis of Autism Spectrum Disorder and referrals to treatment services including but not limited to Occupational Therapy, Speech Therapy, Physical Therapy and Behavior Intervention Services.

Training and education for the PCPs on CHDP program related issues and standards will be provided by both the County and CenCal Health.

Additionally, CHDP Providers are defined as "providers of medical services who have applied to and have been approved by Santa Barbara or San Luis Obispo County's CHDP Program and agree to provide CHDP services according to the

CHDP Health Assessment Guidelines and the CHDP Program regulations in the Health and Safety Code, Section 124025.
CenCal Health assumes administrative responsibility for the CHDP program while Santa Barbara and San Luis Obispo counties ("the County") will retain the authority to recruit, certify, and re-certify CHDP Providers and to monitor their compliance."

Reference Link:
Bright Futures Periodicity Schedule
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

E6: Behavioral Health Treatment

CenCal Health covers Behavioral Health Treatment (BHT) for individuals under the age of 21 in accordance with DHCS EPSDT guidelines. Behavioral Health Treatment services may include, but is not limited to, Applied Behavior Analysis (ABA), behavioral interventions and parent training.

A member may meet criteria for medically necessary Behavioral Health Treatment Services if all of the following criteria are met:

- The member is less than21 years of age
- The member is medically stable
- The member is not in need of a 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities
- Behavioral Health Treatment services are recommended by a licensed physician, surgeon, or psychologist as medically necessary

Medical Necessity

For the EPSDT population, state and federal law define a service as "medically necessary" if the service is necessary to correct or ameliorate defects and physical and/or mental illness and conditions. A BHT services need not cure a condition to be covered. Services that maintain or improve the child's current health condition are considered a clinical benefit and must be covered to "correct or ameliorate" a member's condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems.
Medical necessity decisions are individualized. CenCal does not impose service limitations on any EPSDT benefit other than medical necessity. CenCal complies with mental health parity requirements when providing BHT services.

The following BHT services are not covered by CenCal health as outlined in Medi-Cal All Plan Letter 19-014:

- Services rendered when continued clinical benefit is not expected unless the services are determined to be medically necessary
- Provision or coordination of respite, day care or custodial care or to reimburse a parent, legal guardian or legally responsible person for costs associated with participation under the Behavioral Health Treatment plan

- Treatment where the sole purpose is vocationally or recreationally based
- Custodial care. For purposes of BHT services, custodial care:
    a. Is provided primarily to maintain the member's or anyone else's safety; and,
    b. Could be provided by persons without professional skills or training
- Services, supplies, or procedures performed in non-conventional setting, including, but not limited to, resorts, spas, and camps
- Services rendered by a parent, legal guardian, or legally responsible person
- Services that are not evidence-based behavioral intervention practices

Referral process
Behavioral Health Treatment services require pre-authorization. Timelines for authorization of treatment services are in accordance with standard Medi-Cal guidelines as described in Section H, H7: Timeliness for Authorization Request.

Qualified Providers who meet criteria for recommending BHT services as medically necessary, for any member who is eligible, can submit an ABA referral (RAFB) to the Behavioral Health Department via fax (805) 681-3070, provider portal or the Behavioral Health Department secure link.

Provision of Behavioral Health Treatment Services
BHT services covered by CenCal Health must be an evidence-based intervention identified by the National Standards Project (2015) or by the National Clearinghouse on Autism Evidence & Practice (2020). For all BHT services, the following elements are required and covered by CenCal.
BHT treatment services

- BHT providers will deliver treatment services according to the approved treatment plan by a qualified autism provider who meets the requirements contained in California's Medicaid State plan or licensed provider acting within the scope of their licensure.
- Credible studies and industry standards support that parent participation is associated with improved outcomes. Providers are responsible to coordinate parent participation with treatment planning and service delivery.
- Some portions of direct services may be provided in the school setting when clinically appropriate and medically necessary. Goals and objectives may however not be related to academic functions. If services at a school setting is requested, providers or parents/guardians must provide to CenCal Health a copy of the most recent IEP to provide evidence that the services requested are not duplicative to services provided under the IEP. In addition, documentation must be provided that the school district has approved that the requested services may be provided on the school grounds and the times that the BHT provider is allowed to provide the services.
- The following activities are considered non-covered services:
    - Training of staff
    - Preparation of work prior to the provision of services

  - Accompanying the client to appointments or activities (i.e., shopping, medical appointments) except when the identified client has demonstrated a pattern of significant behavioral difficulties during specific activities, in which case the clinician to actively provide treatment, not to just supervise, control, or contain the member/identified client
  - Transporting the member/identified client in lieu of parental transport. If the member/identified patient has demonstrated a pattern of significant behavioral difficulties during transport, in which case transport is still provided by the parent, and the clinician is present to actively provide treatment to the member/identified client during transport, not to just supervise, control, or contain the member/identified client
  - Assisting the member with academic work or functioning as a tutor, or functioning as an educational aide for the member/identified client in school/daycare or at home
  - Provision of services that are part of an IEP and therefore should be provided by school personnel
  - Provider travel time
  - Transporting parents or other family members
- No more than one month and at least 14 days prior to end of the authorization period, providers may submit a Behavioral Health 50-1 Treatment Authorization Request Form with an updated progress report using an approved template & service logs
  - The BCBA Provider and parent should sign the Treatment plan
  - A parent or guardian must sign all Service Logs for direct care service hours provided
  - Providers must include the documented use of at least one standardized assessment tool, which is an industry standard assessment
- Providers should account for provision of services that are less than hours approved by CenCal through Service Logs and Progress Reports
- Requests for Direct Supervision Hours: CenCal Health authorizes 2 hours of supervision for every 10 hours of direct treatment in accordance with the general standard of care. Individuals who are a Board Certified Assistant Behavioral Analyst (BCaBA) or a Behavioral Management Assistant (BMA) may currently provide some direct supervision of the paraprofessional in an intervention setting if there is documentation that this mid-level supervision has the BCBA's or BMA's guidance.

    a. Requests for hours above the general standard should be submitted with additional documentation for justification that includes support of the Member's individualized treatment plan

    b. BACB Guidelines (2014) recommends a minimum of 2 hours per week of case supervision when direct treatment is 10 hours a week or less

- Requests for Indirect Supervision Hours: CenCal Health will approve up to10 units over the authorization period.

    a. Indirect supervision requests are part of total supervision hours requested
    b. Indirect supervision may be completed by a BCaBA or a BMA under the supervision of a BCBA
    c. Indirect supervision can be used for:
        i. In-office functional analysis and skills assessment
        ii. In-office development of goals/objectives and behavioral intervention plans/reports
        iii. In-office direct staff summary notes
        iv. In office clinical meetings with both paraprofessionals and parents present

Functional Behavioral Analysis (FBA) and Treatment Plan

- Members that meet eligibility criteria for BHT services will be authorized by CenCal for an FBA and development of a treatment plan by a contracted BHT provider
- Upon receiving an approved Referral (RAFB), BHT Providers are required to submit a Behavioral Health 50-1 Treatment Authorization Request Form with up to 10 hours of H0031 to complete an FBA
- The initial authorization to complete an FBA will be for 60 days
    - Providers must use at least one industry approved cognitive and adaptive testing tools to assess the Member's age specific impairments on the
        - FBAExamples: Vineland, Adaptive Behavioral Assessment System-ABAS, Developmental Assessment of Young Children (DAYC), Social Responsiveness Scare, and Social Emotional Learning Edition (SSIS SEL)
- Assessments for the purpose of the FBA (H0031) are allowed at the initiation of services. In the event of a disruption of BHT services lasting 4 or more months, CenCal will approve another FBA again
- BHT Providers are expected to offer members an initial appointment within **10** business days after the approval of the FBA. Providers will be expected to maintain medical records that show the date of the 1st appointment offered, date of 1st appointment scheduled and reason for difference between offered and scheduled appointments
- Providers must document all outreach efforts to the parents to schedule the initial appointment. Providers that are unable to schedule referred members within 30 calendar days or unable to reach parents or legal guardians within 30 calendar days, are requested to contact the referring provider
- Providers that require additional units or an extension to the approved referral or authorization must submit a Behavioral Health 50-1 Treatment Authorization Request Form with justification to the BH Program via the Provider Portal, secure link or by fax to the Behavioral Health Department at (805) 681-3070

- Providers must use CenCal Health's FBA template or an approved template that meets Treatment Plan requirements as outlined in APL19-014
- Upon completion of the FBA assessment, the BHT provider will submit a Treatment Authorization (50-1) to CenCal requesting authorization for services for up to 6 months. BHT providers will upload a copy of the FBA report with the authorization request through the Provider Portal, secure link or fax to the Behavioral Health Department at (805) 681-3070
- BHT providers are expected to initiate services within **10** business days after CenCal authorizes services
- BHT Providers requesting only Social Skills treatment should submit the Social Skills Template with the Behavioral Health 50-1 Treatment Authorization Request Form through the Provider Portal, secure link or fax to the Behavioral Health Department at (805) 681-3070

Behavioral Treatment Plan Requirements:

The behavioral treatment plan must be person-centered and based on individualized, specific, measurable goals and objectives over a specific timeline for the member being treated.

The behavioral treatment plan must be reviewed, revised, and/or modified no less than every six months. The behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer medically necessary under EPSDT medical necessity standards. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary.

The FBA/treatment plan must meet the following criteria:

1) Include a description of patient information, reason for referral, brief background information, clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence based BHT services
2) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors
3) Clearly stated measurable long-, intermediate-, and short-term goals and objectives with dates that are specific, behaviorally defined, developmentally appropriate, socially significant and based upon clinical observation
4) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives
5) Each goal must include the member's current level of need (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated, mastery criteria, date of introduction, estimated date of mastery, specific plan for generalization and report goal as met, not met, modified (include explanation)
6) Utilize evidenced-based BHT services with demonstrated clinical efficacy tailored to the member

7) Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services
8) Include care coordination that involves the parents or caregiver(s), school, state disability programs, and other programs and institutions, as applicable
9) Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours that are medically necessary direct service and supervision
10) Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community
11) Include an exit plan that is specific, measurable, and individualized.

Graduation and Fading of Services

- BHT services must be faded gradually and systematically over time as the member meets treatment goals or the member has met maximum benefit of services. BHT providers will complete a discharge summary and submit to CenCal Health BH Department.
- Members who turn 20 while receiving BHT services, must commence fading of services plan in order to graduate prior to their 21st birthday.

Coordination of Care

CenCal Health is responsible for the provision of Medically Necessary BHT services and requires providers to coordinate with Local Educational Agencies, Regional Centers, and other entities that provide BHT services to ensure that services are not duplicate.

Behavioral Health Treatment Providers are responsible to coordinate care with the primary care physician, other providers and entities closely involved with the member's care. Coordination of care activities may include the following:

- Contacting member's pediatrician, if member may benefit from other therapies such as Occupational Therapy, Speech Therapy, or other medical services.
- Working closely with all other providers such as Regional Center and the Local Education Agency to ensure coordination of services and care.
- Referring the member for case management through CenCal Health.

Approved HCPCS Codes:

HCPCS Codes	Description
H0031 per 15 min	Assessment

H0032 per 15 min	Treatment Plan development (including supervision)
H2014 per 15 min	Skills Training and development (group)
H2019 per 15 min	Therapeutic Behavioral Services
S5111 per session	Home care/family training

Billing/Claims:
Please include the appropriate modifiers only on claims submission:

- No Modifier - BCBA Provider
- HO - Midlevel Qualified Autism Professional
- HM – Paraprofessional

E7: Mental Health Services

Non-Specialty Mental Health Services (NSMHS) are a covered benefit for CenCal Health members when medically necessary and may be provided by a PCP within scope of practice, by a licensed mental health professional employed by a CenCal Health contracted FQHC or a provider contracted with CenCal Health.

CenCal Health covers services for Members (age 21 and older) with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders as defined by the current Diagnostic Statistical Manual of Mental Disorders.

Members under the age of 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment or the presence of a diagnosis; and Members of any age with potential mental health disorders not yet diagnosed.

CenCal Health covers psychotherapy for Members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder.

Types of Services Provided:
The following Non-Specialty Mental Health Services (NSMHS) are covered by CenCal Health include:

- Mental Health evaluation and treatment, including individual, group and family psychotherapy.
- Psychological testing and neuropsychological testing, when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation to a member to establish medical necessity for medication management of a psychiatric or behavioral disorder (No pre-

service authorization required. Treating physician must be the requesting provider. Note: psychiatric consultation in the Emergency Room is not a covered benefit).

Services are covered by CenCal Health even when:

- Services are provided prior to determination of a diagnosis, during the assessment period, or prior to determination of whether NSMHS or SMHS access criteria is met
- Services are not included in an individual treatment plan
- The member has a co-occurring mental health condition and SUD; or,
- NSMHS and SMHS are provided concurrently if those services are coordinated and not duplicated.

CenCal Health also covers up to 20 individual and/or group counseling sessions for pregnant or postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during prenatal period and/or during the 12 months following childbirth. Modifier 33 and pregnancy or postpartum diagnosis code must be submitted on claims for counseling given to prevent perinatal depression.

Risk factors for perinatal depression include:

- A history of depression
- Current depressive symptoms (that do not reach diagnostic threshold)
- Certain socioeconomic risk factors such as low income, adolescent, or single parenthood
- Recent intimate partner violence
- Mental health-related factors such as anxiety symptoms or a history of significant life events

Providers are expected to ensure the frequency of services and treatment plan are in line with the treatment of with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), that results in mild to moderate distress or impairment of functioning.

Specialty Mental Health Services (including crisis response, inpatient and residential treatment, and mental health services to children under EPSDT) will continue to be the responsibility of the County Mental Health Departments. See Section F2 for more information on the criteria for specialty mental health services.

County Mental Health Departments are available for psychiatric consultations to CenCal contracted primary healthcare providers.

Medical Necessity Criteria

- CenCal Health provides non-specialty mental health services (NSMHS)for members under the age of 21 when services correct or ameliorate a behavioral health condition, discovered by a screening service. Behavioral Health services, Non-Specialty Mental Health Services, need not be curative or completely restorative to ameliorate a behavioral health condition.

Services to sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and covered as EPSDT services.

- In accordance with W&I sections 14059.5 and 14184.402, for individuals 21 years of age or older, as service is "Medically Necessary" services when it is reasonable and necessary services to protect life, prevent significant illness or disability or to alleviate severe pain through the diagnosis and treatment of the illness.
- CenCal Mental Health services for the adult population group include all diagnosis DSM V diagnosis as primary focus of treatment **except** diagnoses related to substance use or dependence. (ICD 10: F10 –F 19).
    - Substance use and dependence disorders can be a secondary diagnosis to a primary mental health diagnosis for treatment purposes. Treatment for primary substance use disorders are carved-out to County Substance Abuse Services.

Authorizations & Referral Protocols

- Referrals and Authorizations are not required for psychotherapy or medication management services.
- Prior Authorization is a required for psychological and psychological testing.
    - The Member's Primary Care Physician (PCP) can direct the member to any contracted Psychologist for a psychological evaluation to start the psychological testing authorization process. A psychological evaluation will determine if psychological or neuropsychological testing is clinical indicated and medically necessary.
    - Providers are responsible to submit a Treatment Authorization Request (TAR) to the Behavioral Health Department via fax (805) 681-3070, provider portal or the Behavioral Health Department secure link.
- Members can self-refer or be referred by a mental health provider for psychotherapy or medication management by contacting the CenCal Behavioral Health Department or the County Access line to request mental health services.
- At any time, a Member can choose to seek and obtain an initial mental health assessment from a licensed mental health provider within CenCal Health's provider network. A listing of contracted mental health providers can be obtained on the CenCal website.
- CenCal Health Primary Care Physicians and Mental Health Providers are required to use the Level of Care Screening and transition tools provided by CenCal Health.
- To facilitate collaborative services between healthcare providers and mental health providers, providers should request a signed release of information from Members.
- To avoid duplication of services, providers should ensure that member is not receiving services at the County Department of Behavioral Health. A member may receive a non-duplicative service from the County Department of Behavioral Health or County Substance Use Department and CenCal Health simultaneously.

- Primary Care Physicians who determine a member with positive scores on any substance use, mental health or ACE screening can refer the Member for the mental health services by submitting a Behavioral Health Care Coordination Request form to the Behavioral Health Department via fax (805) 681-3070, or the Behavioral Health Department secure link. The Behavioral Health Department will outreach member to facilitate access to the appropriate level of care.

CenCal Health Contact Information

CenCal Health Behavioral Health Department

☎ Member Line: 1(877) 814-1861
Provider Line: (805) 562-1600
Fax number: (805)681-3070
Secure Link: https://gateway.cencalhealth.org/form/bh

Santa Barbara County Department of Behavioral Wellness

☎ Access Line (24/7) (888) 868 -1649
Psychiatry Consultation Services: 1- 805 681- 5103

San Luis Obispo Department of Behavioral Health

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

Provision of Mental Health services to CenCal Health members

Pursuant to the terms of the provider agreement, participating providers will provide covered mental health services to CenCal members

- In the same manner as services rendered to other clients/patients
- In accordance with accepted medical and mental health standards and all applicable state and/or federal laws, rules, and/or regulations
    - In a quality and cost-effective manner
- Ensure that a member is not receiving duplicate services from the County or another in-network contracted provider.
- Update demographic, office and/or participating provider profile information promptly and in advance
- Refer members to other participating mental health providers when the member may require care outside of the provider's scope or training.
- Obtain a Release of Information and coordinate care with a member's other health/medical care providers as it supports treatment collaboration
- Provide continuous care to a member who requires a County Specialty Mental Health Services (SMHS)until such time as the member is successfully transitioned to County-level services
    - Facilitate access to appropriate frequency of sessions as indicated on the member's initial psychosocial assessment and treatment plan.

Initial Psychosocial Assessment

CenCal Health requires that all new Members have an initial psychosocial assessment during initial encounter(s) with their mental health provider.
An initial psychosocial assessment enables the provider to assess the immediate needs, level of impairment (mild/moderate/severe) and develop a person-centered treatment plan to maintain and/or improve functioning.

Assessment Requirements:

Psychosocial assessments. Psychosocial assessment must include the following information

- Presenting concerns
- Medical history
- Psychiatric history
- History of trauma
- Substance use history
- Developmental history (children and adolescents)
- Allergies/adverse reactions
- Current and past Medications
- Risk assessment
- Mental status exam
- Member strengths
- Cultural factors
- Diagnosis validated by clinical data
- Treatment plan and recommendations including completion of CenCal Level of Care screening instrument

Treatment Plan Requirements

- A **treatment plan** must be developed for each new episode and should be updated as needed to reflect changes/progress of the member. CenCal BH Department recommends that treatment plan be updated every 6 months for psychotherapy services and annually for medication management services.
- Treatment plans must be consistent with diagnoses, have specific, measurable, attainable goals and estimated timeframes for goal attainment or problem resolution.
- The member's participation and understanding of the treatment plan must be documented.
- Informed consent for all medications must be clearly documented including a review of adverse effects of all prescribed medication including potential withdrawal symptoms if the medication is discontinued.
- Should also include a crisis plan for the member.

Progress Notes and Maintenance of Records Requirements

- Providers must retain a record of the type and extent of each service rendered as well as the date and time allotted for appointments and the time spent with patients (California Code of Regulations [CCR], Title 22, Section 51476[a] and 51476[f]).
- Progress Notes should include what psychotherapy interventions were used, and how they benefited the member in reaching his/her treatment goals.
- Medication management providers must indicate in each record what medications have been prescribed, the dosages of each and the dates of initial prescription or refills

Coordination of Care

Mental Health providers are required to coordinate and direct appropriate care for members including:

- Coordinating care with the members PCP, including but not limited to arranging for referrals to other specialists including psychological testing.
- Referring the member to County Specialty Mental Health Services if the Member meets criteria as determined by the required Level of Care Screening.
    - Providers will complete a Level of Care Screening and Transition of Care form and send directly to the Behavioral Health Department by fax or secure link.
- Mental Health providers should coordinator the delivery of care to the member with these providers/participating providers by obtaining required consent and authorization from the member and documenting accordingly in the member's treatment record.

Discharge Planning

Mental Health providers are required to collaboratively plan with Member and other providers as clinically indicated in the discharge plan. The following information must be documented:

- Discharge date
- Discharge summary and clinical recommendations

Approved CPT Codes for Billing/Claims

Psychiatric Diagnostic Interviews are reported one per day, per provider, per member. Providers will submit claims using this code for the initial session with members, except non-physician providers who serve children under the age of 21 who may provide up to five (5) sessions of individual or family therapy without a DSM V primary diagnosis. Every time a member changes providers, the new provider is allowed to claim for a new assessment encounter

Providers can submit claims for these CPT codes when a member has a break in treatment of more than six months with the same provider or after a significant

change in presentation or after a member has shown a change in functioning or symptoms.

Note: Neurocognitive disorders (for example, dementia) and substance-related and addictive disorders (for example, stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a recipient meets criteria to receive psychotherapy.

Psychiatric Diagnostic Procedures

90791	Psychiatric Diagnostic Evaluation without medical services
90792	Psychiatric Diagnostic Evaluation with medical services

Interactive Complexity (CPT 90785)
This is an add-on code that can be billed with 90791, 90792, any individual psychotherapy codes (90832 – 90839), group psychotherapy (90853) or medication management services. The add-on code may be used in the following circumstances:

- when there are specific communication difficulties present (i.e., high anxiety, high reactivity, parent disagreement/behaviors during session)
- evidence/disclosure of a sentinel event and mandated report to a third party
- Use of play equipment, physical devices, interpreter, or translator services to overcome significant language barriers.

The conditions necessitating billing the add-on code must be clearly described in the progress notes.

90785 may not be used for biofeedback services or EMDR services.

Individual Therapy

Individual therapy can be provided and is reimbursable to adults and children with a mental health condition. The following diagnosis are excluded for individual &

Group Therapy Services:

- F10 –F19 as a primary diagnosis (substance abuse),
- F72 & F73 Severe and Profound Intellectual Disability (primary or secondary diagnosis)
- Moderate to Severe Neurocognitive Disorders (i.e., Alzheimer's, Traumatic Brian Injury) (primary or secondary diagnosis)
- Children under the age of 21 are entitled to five sessions of individual or group therapy prior to being diagnosed with a mental health condition
- Individual therapy is limited to a maximum of one and one-half hours per day by the same provider

Providers will submit claims using the following code and a primary ICD-10 code. Claims for children under age 21 provided prior to diagnosis will use Diagnosis code F99

90832	Psychotherapy, 30 min
90834	Psychotherapy, 45 min
90837	Psychotherapy, 60 min
90839	Psychotherapy for crisis, first 60 min
90849	Psychotherapy for crisis each additional 30 minutes
90880	Hypnotherapy

Family Therapy

Family can be provided and is reimbursable to adults or children with a mental health condition. Children under the age of 21 are entitled to five sessions of individual therapy prior to being diagnosed with a mental health condition.

Family therapy services is also reimbursable when provided to children under the age of 21 who has a history of one of the following risk factors:

- Separation from a parent/guardian due to incarceration or immigration
- Death of a parent/guardian
- Foster home placement
- CCS-eligible condition
- Food insecurity, housing instability
- Exposure to DV or other traumatic events
- Maltreatment
- Severe & persistent bullying
- Experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability.

OR

Child has a parent/guardian with at least one of the following risk factors

- Serious illness or disability
- History of incarceration
- Mental Health Disorder
- Substance Abuse Disorder
- History of DV or interpersonal violence
- Teen parent

Family therapy is also reimbursable on an inpatient basis if the member is an infant (under I year of age) who are hospitalized in a neonatal intensive care unit. Claims when the CenCal member is an infant and admitted to a NICU will use diagnosis code P96.9

Family Therapy is limited to a maximum of 50 minutes when the identified client is not present (CPT code 90846) or a maximum of 110 minutes when the client is present (CPT code 90847 plus CPT code 99354)

CPT codes 90846, 90847 and 90853 may not be billed on the same day for the same beneficiary.

Family Therapy must be composed of at least two family members. Providers must bill for family therapy using the CenCal ID of only one family member per therapy

session for CPT codes 90846, 90847 and 99354. For multiple-family group therapy, providers must use the CenCal ID of only one family member per family.

Providers will submit claims using the following CPT codes and an ICD-10 code of the identified client under whose CenCal ID billing is being submitted. Claims for children under age 21 provided prior to diagnosis will use Diagnosis code F99. Claims for children who are at risk of developing a mental health condition, will use Diagnosis code Z 65.9

Some examples of evidence-based family therapy are:

- Child-Parent Psychotherapy (ages 0 thru 5)
- Parent Child Interactive Therapy (ages 2 thru 12)
- Cognitive-Behavioral Couple Therapy (adults)

Providers will submit claims using the following CPT codes

CPT Code	Description
90846	Family Psychotherapy (without client present) 50 min
90847	Family Psychotherapy, (with client present) 50 min
90849	Multiple-family group therapy
99354	Prolonged services in the outpatient setting requiring direct patient contact beyond the time of the usual service, first hour

Group Therapy

Group Therapy is defined as consisting of at least two but not more than eight persons at any session. There is not restriction as to the number of CenCal members who must be included in the group's composition. Group Therapy are expected to be in duration at least one and one-half hours.

Providers will submit claims using CPT code 90853 and ICD 10 diagnosis code.

Medical Team Conferences

Case Conferences must include a minimum of two health care professionals from different specialties or disciplines who provide direct care to the patient. Not more than one individual from the same specialty may report 99366-99368 at the same encounter. The limit is one per day, per provider.

Reporting participants should record their role in the conference, contributed information, and subsequent treatment recommendations.

CPT Code	General Code Description
99366	Medical team conference, recipient and/or family present per 30 minutes,
99368	Medical team conference, recipient and/or family not present, per 30 minutes

Medication Management services

Psychiatrists, psychiatric Physician Assistants and psychiatric Nurse Practitioners may bill for the following evaluation and management codes: 99202 thru 99255, 99304 thru 99337, 99341 thru 99350 and 99417. For more information, refer to the *Evaluation and Management (E&M)* section of the appropriate Part 2 Manual.

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Psychotherapy add-on codes to E/M services: (CPT 833, 936, 938). Providers must clearly document in the member's medical record the time spend providing psychotherapy services. In other words, time spend on the E/M service and the psychotherapy service may not be bundled but must be indicated separately. Providers are advised that psychotherapy services must be individualized and not comprise of "cut and paste" interventions that are the same across different patients or different sessions for the same patient.

Psychological and Neuropsychological testing

Psychological and Neuropsychological testing requires a pre-services authorization. Providers requesting to complete Psychological or Neuropsychological testing must submit a Behavioral Health Treatment Authorization Request (50-1) with a completed Psychological/Neuropsychological Testing Pre-Service Authorization Request Form to the Behavioral Health Department via fax (805) 681-3070, provider portal or the Behavioral Health Department secure link.

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

Neuropsychological Testing

Neuropsychological testing (CPT codes 96132, 96133, 96136 thru 96139 and 96146 [when billing for neuropsychological testing]) is considered medically necessary:

- When there are mild deficits on standard mental status testing or clinical interview, and a neuropsychological assessment is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging, or the expected progression of other disease processes; or
- When neuropsychological data can be combined with clinical, laboratory and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or
- When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, especially when the information will be useful in determining a prognosis or informing treatment planning by determining the rate of disease progression; or
- When there is a need for pre-surgical or treatment-related cognitive evaluation to determine whether it would be safe to proceed with a medical or surgical procedure that may affect brain function (for example, deep brain stimulation, resection of brain tumors or arteriovenous malformations, epilepsy surgery, stem cell transplant) or significantly alter a patient's functional status; or

- When there is a need to assess the potential impact of adverse effects of therapeutic substances that may cause cognitive impairment (for example, radiation, chemotherapy, antiepileptic medications), especially when this information is utilized to determine treatment planning; or
- When there is a need to monitor progression, recovery, and response to changing treatments, in patients with CNS disorders, in order to establish the most effective plan of care; or
- When there is a need for objective measurement of patients' subjective complaints about memory, attention, or other cognitive dysfunction, which serves to inform treatment by differentiating psychogenic from neurogenic syndromes (for example, dementia vs. depression), and in some cases will result in initial detection of neurological disorders or systemic diseases affecting the brain; or
- When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders; or
- When there is a need to determine whether a member can comprehend and participate effectively in complex treatment regimens (for example, surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome patients; transplant or bariatric surgeries in patients with diminished capacity), and to determine functional capacity for health care decision making, work, independent living, managing financial affairs, etc.; or
- When there is a need to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain-injured patients; or
- When there is a need to establish treatment planning through identification and assessment of neurocognitive conditions that are due to other systemic diseases (for example, hepatic encephalopathy; anoxic/hypoxic injury associated with cardiac procedures); or
- Assessment of neurocognitive functions in order to establish rehabilitation and/or management strategies for individuals with neuropsychiatric disorders; or
- When there is a need to diagnose cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional or physical demands.

Neuropsychological testing is not considered medically necessary when:

- The patient is not neurologically and cognitively able to participate in a meaningful way with the requirements necessary to successfully perform the tests; or

- Used as screening tests given to the individual or general populations; or
- Used as a screening test for Alzheimer's dementia; or
- Administered for educational or vocational purposes that do not inform medical management; or
- Performed when abnormalities of brain function are not suspected; or
- Used for self-administered or self-scored inventories, or screening tests of cognitive function such as AIMS, or Folstein Mini Mental Status Exam (MMSE); or
- Repeated when not required for medical decision making, (for example, to make a diagnosis, or to start or continue rehabilitative or pharmacological therapy); or
- Administered when the patient has a substance abuse background and any one of the following apply:
    - the member has ongoing substance abuse such that test results would be inaccurate, or
    - the member is currently intoxicated; or
- The member has been diagnosed previously with brain dysfunction, and there is no expectation that the testing would impact the member's medical management

The appropriate test scoring or written test report procedure code must be billed on the same claim as the test administration. Pre-test interviews, pre-test instructions and test materials are not separately reimbursable. Compensation for these services has been included in the maximum rate for test administration.

CPT Code	General Code Description	Frequency Limits
96132	Neuropsychological testing evaluation services; first hour	One per year, any provider
96133	Neuropsychological testing evaluation services; each additional hour	Two per year, any provider
96136	Psychological or neuropsychological test administration and scoring, two or more tests; first 30 minutes	One per year, any provider
96137	Psychological or neuropsychological test administration and scoring, two or more tests; each additional 30 minutes	Nine per year, any provider
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes	One per year, any provider
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes	Nine per year, any provider

96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	One per year, any provider

E8: Substance Use Services

CenCal Health provides covered Substance Use Disorder services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, and illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children recommendations and United States Preventive Services Taskforce grade A and B recommendations for adults.

Members who are identified as requiring alcohol and/or Substance Use Disorder services must be referred to County Department for Substance Treatment Services. For Members receiving alcohol or Substance Use Disorder services through County Departments, CenCal Health will continue to provide all Medically Necessary covered services and coordination and referral of services between CenCal providers and other treatment programs or the Member.

CenCal providers may prescribe medications for addiction treatment (also known as medication-assisted treatment or MAT) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings.

CenCal Health will continue to provide medical case management services for members receiving Substance Use Disorder services from the County Department.

Medical Necessity

For members under 21 years of age, Covered Substance Use Disorder services are Medically Necessary if they are necessary to correct or ameliorate a mental health or substance use condition discovered by an EPSDT screening. Substance Use Disorder services need not be curative or restorative to ameliorate a substance use condition. Substance Use Disorder services that sustain, support, improve, or make more tolerable a substance use condition are considered to ameliorate a substance use condition.

Covered Services

CenCal Health covers all Medically Necessary Substance Use Disorder services for Members including:

- Emergency room professional services as described in 22 CCR section 53855
- Facility charges for emergency room visits that do not result in a psychiatric admission
- Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services required by Members to access Medi-Cal covered Substance Use Disorder services.

Screening

Screening for unhealthy alcohol and drug use is only reimbursable when a validated screening tool is used. Alcohol use screenings are billable using HCPCS code G0442 and drug use screenings are billable using HCPCS code H0049. Validated screening tools include, but are not limited to:

- Cut down Annoyed Guilty Eye-opener Adapted to Include Drugs (CAGE-AID)
- Tobacco, Alcohol, Prescription medication and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

Note: G0442 is reimbursable when the single NIDA Quick Screen alcohol-related question is used without including the additional NIDA Quick Screen questions.

Brief Assessment

When a screen is positive, providers should use an appropriate validated assessment tool to determine whether an alcohol or substance use disorder is present. CenCal Health permits billing for alcohol and/or drug screening when a validated alcohol and/or drug assessment tool is used without initially using a validated screening tool.

Validated assessment tools include, but are not limited to:

- NIDA-modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)

Brief Interventions and Referral to Treatment

Members whose brief assessment reveals probable alcohol or substance use disorder must be offered a referral for further evaluation or for treatment, including medications for addiction treatment (MAT) as appropriate.

CenCal Health reimburses alcohol and/or drug brief interventions services using HCPCS code H0050. Brief interventions include alcohol misuse counseling, counseling a patient regarding the need for further evaluation or referral to

treatment when an alcohol and/or drug use disorder is suspected. There is no minimum number of minutes for brief interventions, but they must include the following:

- Providing feedback to the patient regarding screening and assessment results
- Discussing negative consequences that have occurred and the overall severity of the problem
- Supporting the patient in making behavioral changes
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if

Provider resources for brief interventions include:

- Brief Negotiated Interview (BNI):*https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Brief_Negotiated_Interview-Algorithm.pdf*
- The Substance Abuse and Mental Health Services Administration (SAMHSA) website: *https://www.samhsa.gov/sbirt/resources*
- Information about treatment programs may be found at:
  - *https://www.samhsa.gov/find-help/national-helpline* or
  - https://www.dhcs.ca.gov/individuals/Pages/SUD_County_Access_Lines.aspx

Documentation Requirements

Patient medical records must include:

- The service provided, for example: screen and brief intervention
- The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record)
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
- If a referral to an alcohol or substance use disorder program was made

Billing/Claims

Billing Code	General Code Description	Frequency Limit
99406	Tobacco cessation, 3 to 10 minutes	1 per day
99407	Tobacco cessation, more than 10 minutes	1 per day
G0442	Annual alcohol misuse screening, 15 minutes	1 per year, per provider
H0049	Drug use screening	1 per year, per provider
H0050	Alcohol and drug services, brief intervention	1 per day, per provider

Referral process County Alcohol and Drug Services
San Luis Obispo County Alcohol & Drug Services:

- CenCal Health Primary Care Providers and Mental Health providers who determine a member would benefit from Substance Use Treatment Services can submitting a Behavioral Health Care Coordination Referral to the Behavioral Health Department via fax (805) 681-3070, provider portal or the Behavioral Health Department secure link.
- Members can self- refer or can be referred by a CenCal Health provider by calling County ACCESS Line at (800) 838-1381 and ensuing they have the following information: member identification information and current contact information, name and contact information of referring provider, signed authorization to release information and results of the last physical examination that completed within the previous 12 months.

Santa Barbara County Alcohol & Drug Services:

- CenCal Health Primary Care Providers and Mental Health providers who determine a member would benefit from Substance Use Treatment Services can submitting a Behavioral Health Care Coordination Referral to

  the Behavioral Health Department via fax (805) 681-3070, provider portal or the Behavioral Health Department secure link.
- Members can self-refer or can be referred by a CenCal provider by calling County ACCESS line at (888) 868-1649 and ensuing they have the following information: member identification information and current contact information, name and contact information of referring provider, signed authorization to release information and results of the last physical examination that completed within the previous 12 months.

E9: Non-Emergency Medical Transportation Services and Non-Medical Transportation

Non-Emergency Medical Transportation (NEMT) services are accessible for members whose medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and specialized transportation is required for the purpose of obtaining needed medical care.

NEMT requires prior authorization (TAR). CenCal Health reviews the 'Physician Certification Statement' (PCS) form for medical necessity. This form can be filled and signed by the member's physician, dentist, podiatrist, physical or occupational therapist or mental health or substance use disorder provider. To prevent denials or delays of transports, a completed PCS form with the appropriate NEMT type, start date and duration must be received by CenCal Health. Ventura Transit System (VTS) is CenCal Health's transportation vendor. To schedule transportation services, members or providers may contact VTS directly at (855) 659-4600. *Prior authorization is not required when the member is being transferred from an emergency department to an inpatient setting, or from an acute care hospital immediately following an inpatient stay at the acute level of care to a skilled nursing facility, an intermediate care facility, imbedded psychiatric units, free standing psychiatric inpatient hospitals or psychiatric health facilities.*

The 'Physician Certification' form must include *at a minimum*, the following components:

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

d) **Certification Statement:** The physician is required to certify that medical necessity criteria were met to determine the prescribed mode of transportation.

To view or print the 'Physician Certification' form, please go to www.cencalhealth.org.

Completed and signed Physician Certification forms should be submitted to CenCal Health, Utilization Management (UM) Department via fax or uploaded securely through the File Drop Link:

- CenCal Health UM Fax: 805-681-3071
- CenCal Health's Secure File Drop Link: https://transfer.cencalhealth.org/filedrop/hs

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

1. **Ambulance:**
    a. Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
    b. Transfers from an acute care facility to another acute care facility.
    c. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
    d. Transport for members with chronic conditions who require oxygen if monitoring is required.

2. **Gurney/Litter Van:** For members whose medical and physical condition does not meet the need for NEMT via Ambulance but meets both the following:
    a. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport

   b. Requires specialized safety equipment over and above what is normally available in passenger cars, taxicabs or other forms of public conveyance

3. **Wheelchair Van:** For members whose medical and physical condition does not meet the need for NEMT via Gurney/Litter Van but meets any of the following:
   a. Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport
   b. Requires that the member be transported in a wheelchair, receive assistance to and from the residence, vehicle and/or place of treatment because of a disabling physical or mental limitation
   c. Requires specialized safety equipment that is considered over and above what is normally available in private vehicles, taxicabs or other forms of public conveyance

4. **Air:** NEMT via air is necessary only when practical considerations render ground transportation as not feasible due to the member's medical condition. The medical necessity for NEMT via Air must be included in the Physician Certification form.

Non-Medical Transportation (NMT)

Effective October 1, 2017, Non-Medical Transportation Services are covered and provided through CenCal Health for all Medi-Cal services, including those not covered by CenCal Health's contract. Services that are not covered under the CenCal Health contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.

The following NMT services are covered:

Round trip transportation for a member by passenger car, taxicab, bus or other form of public or private conveyance (private vehicle), as well as mileage reimbursement for medical, mental health or substance use treatment purposes when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets. Before getting approval for mileage reimbursement, a member must state to CenCal Health by phone, by email or in person that they tried to obtain all other reasonable transportation choices and could not obtain one. The NMT request must be the least costly method of transportation that meets the member's needs.

- Round trip NMT is available for the following:

  - Medically necessary covered services.
  - Members picking up drug prescriptions at their local pharmacy
  - Members picking up medical supplies, prosthetics, orthotics and other equipment.
  - Members requiring transportation from an out-of-county psychiatric hospital to their home or a crisis residential treatment facility

- NMT must be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- CenCal Health may use prior authorization processes for approving NMT services.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, CenCal may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. CenCal must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service and is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- CenCal Health does not cover trips to a non-medical location or for appointments that are not medically necessary.

- For private conveyance, the member must attest to CenCal in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license.
  - Has no working vehicle available in the household.
  - Is unable to travel or wait for medical or dental services alone.
  - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Authorization

- VTS determines the transportation benefit to be provided to the member based on the outcome of a series of questions completed during the intake screening from a triage screening form provided by CenCal Health.
- If determined, NMT request is for a local CenCal Health/Medi-cal contracted provider, no authorization is required and VTS will coordinate the transport.
- If the NMT request is for an out of area trip, CenCal Health requires an authorization to be obtained from CenCal Health's Member Services Department. Once authorization is in place, VTS will then coordinate the out-of-area transport.
- NMT services do NOT require a Physician Certification Statement (PCS) Form.

NMT does not apply if:

- An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service.

You need assistance from the driver to and from the residence, vehicle or place of treatment due to physical or medical condition.

Members and/or Providers may contact Ventura Transit System (VTS) directly at (855) 659-4600 for transportation services or CenCal Health's Member Services Department at
(877) 814-1861 for assistance.

To view or print the Non-Emergency Medical & Non-Medical Transportation Services Reference Guide, please go to www.cencalhealth.org.

E10: Importance of Fluoride Varnish

Topical application of fluoride varnish is a covered benefit for pediatric CenCal Health members.

Tooth decay is one of the most common chronic diseases of childhood. Topical fluoride varnish is more effective in preventing tooth decay than other forms of topical fluoride and is more practical.

The early application of fluoride varnish protects the primary teeth and should be performed after the first tooth erupts until age five. It can be swabbed directly onto the teeth in less than three minutes and sets within one minute of contact with saliva. The application requires no special dental equipment and can be applied with minimal training.

Because many dentists are not willing to see young children, primary care physicians or trained nurses and medical assistants under MD Rx have an opportunity to help prevent tooth decay by applying fluoride varnish.

Billing for Fluoride Varnish

- Use CPT code 99188 - topical application of fluoride.
- Reimbursement includes all materials and supplies needed for the application.
- Once teeth are present, treatment is covered up to 3 times in a 12-month period.
- Fluoride Varnish may be applied by
    - Medical Professionals
    - Any trained person with signed guardian permission and under a doctor/dentist prescription or protocol
    - In a community setting such as school/health fair or government program

For staff trainings or other questions please contact our Population Health Team at populationhealth@cencalhealth.org.

Reference Link:
CenCal Health Fluoride Varnish for Childhood Oral Health Training Video
https://vimeo.com/255463545

E11: Postpartum Care

CenCal Health has carved out postpartum visits from the global reimbursement for obstetric care so that providers can bill for these visits separately fee-for-service. This is an added financial incentive to complete timely postpartum care within one to twelve weeks after birth, followed by ongoing care as needed. OB providers do not receive a denial when billing globally without the inclusion of this service, so it is important to bill for postpartum visits separately. Providers can bill CenCal Health for this service using CPT code Z1038.

E12: Steps to Take for Tobacco Cessation

Documenting patient tobacco use (including cigarettes, cigars, chew, vapes, e-cigarettes, etc.) and providing brief clinical interventions is important to quality patient care. Clinician-delivered brief interventions enhance motivation and increase the likelihood of successful and multiple quit attempts.

The steps below outline CenCal Health's preferred methods for tobacco cessation.

1. Ask all adolescent, adult, and pregnant patients if they are a current smoker or exposed to tobacco smoke. **Specifically ask about use of vapes/e-cigarettes.**

2. Document patient tobacco use using one of the following identification methods:
    - Add tobacco use as a vital sign in the chart or EMR
    - Use ICD-10 codes in the medical record
        - Codes for tobacco use
        - Codes for vape/e-cigarette use
    - Place a chart stamp in the medical chart

3. If identified as a smoker, discuss smoking cessation regiments (quitting options) with the patient.
    - Non-pregnant adults should be prescribed FDA approved pharmacotherapy

4. Once you establish the appropriate cessation regimen for the patient, prescribe the appropriate cessation agent.
    - Please see **https://medi-calrx.dhcs.ca.gov/** for the current formulary.
    - If applicable, instruct patient to take their prescription to the pharmacy for fulfillment.

5. Refer patient to **individual, group, and telephone** counseling. Counseling is strongly recommended for cessation success.

    Please note: all pregnant patients who smoke should be offered at least one face-to-face tobacco cessation counseling session per quit attempt.

- **Individual counseling**
  This can be performed at your office visit, and can include one of the following validated counseling methods:
    - 5 As (Ask, Advise, Assess, Assist, Arrange)
    - 5 Rs (Relevance, Risks, Rewards, Roadblocks, Repetition)
    - Other method of your choice

  Use the following CPT codes for reimbursement for individual counseling:
    - **99406**: symptomatic; smoking and tobacco use cessation counseling visit, greater than 3 minutes, up to 10 minutes
    - **99407:** symptomatic; smoking and tobacco use cessation counseling visit; greater than 10 minutes

- **Group counseling**
  Refer patient to a group cessation class. Contact the local Public Health Department for information on local classes and support services:
  Santa Barbara County: (805) 681-5407
  San Luis Obispo County: 805-781-5540

- **Telephone counseling**
  Refer patient to the Kick It California Helpline at (800) 300-8086
    - Give the patient a flyer with contact information for the Kick It California
    - Or log onto to Helpline's web referral to refer the patient directly. Helpline counselors will then contact patient's personal phone

  *Note: Refer **all** pregnant patients who smoke to Kick it California

Notes:

- CenCal Health members who have questions about this benefit or need assistance can call **Member Services** at (877) 814-1861
- For more information on tobacco cessation clinical guidelines, refer to "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008, " linked below.
- For training on tobacco cessation counseling or related topics, please refer to attachment B in the DHCS resource linked below.

Reference Link:

- https://ctri.wisc.edu/wp-content/uploads/sites/240/2017/09/icd10.pdf
- https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.pdf
- https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5rs.pdf
- https://kickitca.myshopify.com/collections/all
- https://www.kickitca.org/patient-referralhttps://www.ahrq.gov/prevention/guidelines/tobacco/clinicians/update/index.html

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf

E13: Whole Child Model (WCM) and California Children's Services (CCS)

As of July 1, 2018, CenCal Health began administering the Whole Child Model (WCM) for the California Children's Services (CCS) program for all eligible pediatric members (0-20 years old). The WCM is a delivery system that provides comprehensive, coordinated services for children and youth with special healthcare needs through a patient and family centered approach, ensuring all necessary care for the whole child is received not only for the CCS condition. In the WCM, CenCal Health is responsible for Neonatal Intensive Care Unit (NICU) acuity review, High Risk Infant Follow-Up (HRIF) eligibility, authorization for services and case management. The WCM program provides medical case management and care coordination to eligible children. Services offered include diagnostic exams, medical treatment, transportation assistance, and physical and occupational therapies. CCS members are assigned to a PCP who is CCS paneled and contracted with CenCal Health.

The CCS Counties are responsible for determining CCS eligibility and paneling of CCS providers. Examples of CCS-eligible medical conditions include, but are not limited to, cystic fibrosis, sickle cell disease, hemophilia, cerebral palsy, heart disease, cancer, and traumatic injuries.

For CCS clients who do not have CenCal Health, the CCS County assumes financial responsibility and care management.

CCS Eligibility

The CCS program delivers specialized services to financially and medically eligible children under the age of twenty-one (21) who have CCS eligible conditions, as defined in Title 22, California Code of Regulations.

If a provider suspects that a child has a CCS eligible condition, he/she should contact the member's Primary Care Physician (PCP) and inform them of such suspicion. The member's PCP will then make a referral to CCS for eligibility review. Referrals could be made to the local County CCS office or CenCal Health.

Referrals

A PCP issues a Referral Authorization Form (RAF) in order to refer an assigned member to a CCS paneled specialist for medically necessary services not generally provided by a PCP. For a list of services that do not require a RAF, please reference CenCal Health's RAF Exceptions List.

Authorizations

CenCal Health will review requests for services of CCS members based on CCS medical eligibility criteria and guidelines. For services that are not related to the CCS condition, CenCal Health will utilize its current medical necessity criteria.

Reference Link:
CenCal Health Pharmacy Services
www.cencalhealth.org/providers/pharmacy/forms-downloads-fax/

CenCal Health Referral Authorization
www.cencalhealth.org/providers/authorizations/referrals/

CenCal Health's RAF Exceptions List
https://www.cencalhealth.org/~/media/files/pdfs/providers/for-providers/provider-materials/202104rafexceptionslist.pdf?la=en

E14: Community Based Adult Services (CBAS)

CBAS is a benefit available to eligible Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care. Eligibility to participate in CBAS is determined by CenCal Health.

CBAS centers offer therapeutic and social services in a community-based day healthcare program. Services are provided according to a six-month plan of care developed by the CBAS center's multidisciplinary team and CenCal Health's Health Services team. The services are designed to prevent early and unnecessary institutionalization and to keep recipients as independent as possible in the community.

CBAS services include:

- an individual assessment
- professional nursing services
- physical, occupational and speech therapies
- mental health services
- therapeutic activities
- social services
- personal care
- a meal
- nutritional counseling
- transportation to and from the participant's residence and the CBAS center

Billing Codes and Reimbursement Rates:
The billable reimbursement rate is determined by the date of service.

HCPCS Code	Description	Rate*
H2000	Comprehensive multidisciplinary evaluation	80.08
S5102	Day care services, adult; per diem	76.27
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter.	64.83

Authorization:

CBAS initial assessment and transition days do not require a TAR. CBAS regular days of attendance require a Treatment Authorization Request (TAR). Please refer to Section H of the Provider Manual.

E15: Palliative Care

Description of Palliative Care Benefits

Palliative Care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The benefit includes access to a multidisciplinary care team that coordinates and supports the member's advance care planning and their medical, mental, emotional, and spiritual needs. Palliative Care is delivered on a predominantly outpatient basis; however, the benefit is available to members at an inpatient facility.

Palliative Care does not require the Member to have a life expectancy of six months or less and may be provided concurrently with curative care. The provision of Palliative Care shall not result in the elimination or reduction of any covered services or benefits and shall not affect a beneficiary's eligibility to receive any services, including Home Health Services, for which the beneficiary may not have been eligible in the absence of receiving Palliative Care.

Member Eligibility Criteria for Palliative Care

Palliative care is available to adult and pediatric members. The Palliative Care benefit shall only apply to CenCal Health Medi-Cal Members who are not Medicare/Medi-Cal (dual-eligible) Members. A Member who is receiving Palliative Care may choose to transition to Hospice Care if they meet the Hospice eligibility criteria. Members may not be concurrently enrolled in Hospice Care and Palliative Care.

Member eligibility for Palliative Care services includes the minimum criteria as set by the DHCS All Plan Letter (APL) 18-020, or successor policy.

In addition to the State minimum criteria for adult Members (21 years and older), CenCal Health eligibility criteria for adult Palliative Care will also include the following:

- Members with Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Cancer, or Liver disease who may not meet the disease specifications set by DHCS but who are clinically deteriorating and whose death within a year would not be unexpected based on clinical status.
- Members who meet DHCS criteria but have who still have reservations about participating in Advance Care Planning or foregoing emergency room treatment.
- Members who have other advanced or progressive illnesses whose death within a year would not be unexpected based on clinical status. Included illnesses are advanced ALS, Multiple Sclerosis, Interstitial Lung disease, Primary Pulmonary Hypertension, HIV/AIDS, and end stage rheumatologic illnesses.

- Illnesses not indicated above may be considered on a case-by-case basis with approval from a CenCal Health Medical Director.

Medical records should be available for any Member upon request from CenCal Health to determine eligibility for the benefit.

Authorization Requirements for Palliative Care Program Benefit

A TAR (Treatment Authorization Request) for initial Palliative Care assessments and consultations is auto approved. It includes a 7-day global period for services rendered while exploring the benefit. The request may be submitted by a Member's PCP, specialist, or a contracted CenCal Health Palliative Care provider. It is recommended to submit supporting documentation particularly for Members under the age of 21. Members may contact CenCal Health directly to self-refer for services. There is an add-on payment for the completion of a POLST (Physician Orders for Life Sustaining Treatment) form.

After completion of the initial assessment and consultation and the Member has decided to participate in the Palliative Care Program, a TAR is required to commence ongoing Palliative Care Program services. A TAR will be required for every subsequent six months (up to twelve [12] units, where each unit is a two-week global period) of Palliative Care Program services, re-certifying the Member's qualifying condition along with an updated Plan of Care and/or recent progress notes.

Palliative Care organization providers must maintain appropriate medical records documenting all services rendered to members, and submit Palliative Care utilization data and other records as required by CenCal Health to substantiate the services rendered.

You can access the Palliative Care located within Provider Training Library | CenCal Health Insurance Santa Barbara and San Luis Obispo Counties website page.

Consideration of Prospective Providers for Palliative Care Agreement with CenCal Health

Provider organizations should meet the following criteria to be considered for a contract with CenCal Health for Palliative Care Program services:

- Organization and all providers and subcontractors are enrolled Medi-Cal providers
- Clinical staff are trained in Palliative Care from an appropriate credentialing or oversight organization
- Medical Director must have specialized and current Palliative Care training and/or certification as a Palliative Care physician
- 24/7 Telephonic Care with access to a nurse who has access to the Member's medical record and Plan of Care to assist with informed decision-making

- Ability to collect and submit all required clinical, encounter, and quality data as required by CenCal Health
- Core staffing identified in a roster to include, at-minimum, a medical director, registered nurse(s), social worker(s), administrator with:
    - Palliative Care training and/or certification obtained to-date, and/or any future training/certification planned.
    - Pediatric training and/or certification for Providers able to offer Palliative Care services to pediatric Members (under the age of 21) for staff who would render services to pediatric Members, appropriate to their scope of services.
- If the organization will contract for some of these services, please describe the contractual arrangements.
- If the organization is not a Hospice and/or Home Health organization, submission of a letter or Memorandum of Understanding (MOU) with local Hospice and/or Home Health organization(s) who can accept patients who need those services is required.

Reference Link:
CenCal Health Palliative Care Training
https://www.cencalhealth.org/providers/provider-training-resources/provider-training-library/

E16: Diabetes Prevention Program

Description of Diabetes Prevention Program
Diabetes Prevention Program ("DPP") is an evidence-based lifestyle change program, taught by peer coaches, designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. The Centers for Disease Control and Prevention ("CDC") established the National DPP and set national standards and guidelines, also known as the CDC Diabetes Prevention Recognition Program ("DPRP"), for the effective delivery of the national DPP lifestyle change program.

Provider Requirements for DPP Agreement with CenCal Health
Provider organizations must be actively certified by the CDC as a recognized DPP program in connection with the DPRP program and Medi-Cal DPP standards. Providers who are in the process of obtaining CDC DPP certification may contact CenCal Health to initiate the contracting process.

Members must be screened per CDC guidelines to ensure they meet CDC DPRP participant eligibility for the benefit. Peer coaches rendering for the provider organization must be adequately trained to administer the DPP curriculum in accordance with the CDC DPRP program guidelines. Providers must maintain adequate documentation of all services, including program milestones (when met), and must furnish any documentation required by CenCal Health to substantiate the services billed.

Due to the serial nature of DPP coursework, Providers must offer a new series of DPP courses within their service area at least quarterly to ensure adequate access for Members to the benefit.

Authorization Requirements for DPP Program Benefit
A RAF from a Member's PCP is required by CenCal Health for payment of any DPP program services. Referral Providers and case managers can direct Members to contact their PCP for a referral to CenCal Health contracted DPP provider. A contract for DPP services is required to be eligible to receive a RAF for DPP services. Providers should refer to the Medi-Cal State Manual and State website for details on coding and billing for services.

E17: Blood Lead Level Testing in Children

In accordance with DHCS contractual obligations, all providers who see children up to 6 years of age must ensure they are tested for blood lead levels (BLL) in accordance with the prevailing clinical guidelines. Providers must test children following the Bright Futures Periodicity Schedule as published by the American Academy of Pediatrics AAP Periodicity Schedule.

Providers must also:

- Provide oral or written anticipatory guidance at each periodic health assessment (6 months – 72 months of age) about the harms of lead exposure
- Report BLL screening results to the Childhood Lead Poisoning Prevention Branch (CLPPB)
- Document the reasons for not screening a child for BLL in the child's medical record

Monitoring
Through the DHCS-required Facility Site Review process, CenCal Health verifies that applicable contracted providers reliably report BLL results to CLPPB, as required.

On a monthly basis, CenCal Health monitors the prevalence and timeliness of BLL testing in its membership, using the prevailing industry-standard methodology.

Providers will be notified monthly of all assigned members due for BLL screening as lead testing is one of the priority measures in CenCal Health's Quality Care Incentive Program (QCIP). The Gaps in Care Reports are located within the Provider Portal.

Billing
Providers can bill CenCal Health for BLL testing using the following CPT procedure code 83655.

Reference Link:
Recommendations for Preventative Pediatric Health Care
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.220656859.25343377.1667942832-1640830407.1667942831

CenCal Health's Quality Care Incentive Program
https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

CenCal Health Provider Portal
https://web.cencalhealth.org/Account/Login?ReturnUrl=%2F

E18: Medical Pharmacy, Authorizations for Physician-Administered-Drugs (PADs)

CenCal Health and the Pharmacy Services Team is responsible for a variety of activities including, but not limited to:

- Clinical pharmacy adherence
- Drug Utilization Review (DUR)
- Utilization management associated with pharmacy services (Physician-Administered-Drug) billed on a medical and institutional claim.

CenCal Health defines the utilization management of Physician-Administered-Drugs on the medical benefit as **Medical Pharmacy Management**. Medical Pharmacy Management includes clinical guideline criteria, physician-administered-drug authorization request review, and preferred medical pharmacy drug programs.

A comprehensive overview of the Medical Pharmacy Program can be found on the CenCal Health Pharmacy Services webpage. In addition, instructions on how to submit an authorization request through the medical benefit can be found on the CenCal Health Authorizations webpage.

Reference Link:
CenCal Health Pharmacy Services:
https://www.cencalhealth.org/providers/pharmacy/

CenCal Health Authorization Page:
https://www.cencalhealth.org/providers/authorizations/

E19: Doula Services

As of January, 2023, CenCal Health covers Doula Services which include health education; advocacy; and physical, emotional, and nonmedical support provided before, during, and after childbirth or end of a pregnancy, including throughout the postpartum period. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

Doula services require a written recommendation that must be submitted to CenCal Health by a physician or other licensed practitioner of the healing arts acting within their scope of practice. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a Network Provider.

Covered Services:
A recommendation for services submitted to CenCal Health via a Treatment Authorization Request may be submitted for the following:

- One initial visit.
- Up to eight additional one-hour visits that may be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery, abortion or miscarriage.
- Up to two extended three-hour postpartum visits after the end of pregnancy.

These requests will be automatically approved by CenCal Health. The extended three-hour postpartum visits do not require the Member to meet additional criteria or receive a separate recommendation. An additional recommendation from a physician or other licensed practitioner of the healing arts acting within their scope of practice is required if additional visits are medically necessary during the postpartum period. The additional recommendation can include up to nine additional one-hour postpartum visits and will be reviewed for authorization by CenCal Health.

The initial visit must be no less than 90 minutes. All other visits must be no less than 60 minutes. Visits are limited to one per day, per Member. Only one Doula may bill for services provided to the same Member on the same day. One prenatal visit or one postpartum visit maybe provided on the same day as labor and delivery, abortion, or miscarriage support.

Doulas may not bill Medi-Cal for a postpartum visit if they provided overnight postpartum care on the same day for a fee billed to the Member.

Doulas are required to document the date and time/duration of services provided to Members. Documentation should reflect information on the nature of care and service provided and support the length of time spent with the patient that day. Documentation shall be accessible to the Department of Healthcare Services (DHCS).

To be eligible for credentialing and contracting with CenCal Health, Doulas must:

- Be at least 18 years old
- Possess an adult/infant Cardiopulmonary Resuscitation (i.e., CPR) certification from the American Red Cross or American Heart Association
- Have completed Health Insurance Portability and Accountability Act (HIPAA) training;
- Have a National Provider Identifier (NPI) number (request one at
- https://nppes.cms.hhs.gov);
- Meet qualification either through the training or experience pathway, as follows:
  o Training:
    - Complete a minimum of 16 hours of training in the following areas:
      - Lactation support
      - Childbirth education
      - Foundations on anatomy of pregnancy and childbirth

- Nonmedical comfort measures, prenatal support, and labor support techniques
- Developing a community resource list

- Provide support at a minimum of three births

o Experience:

- At least five years of active doula experience in either a paid or volunteer capacity within the previous seven years.
- Attestation to skills in prenatal, labor, and postpartum care as demonstrated by the following:
  - Three written client testimonial letters or professional letters of recommendation from the past seven years. Professional letters from any of the following are acceptable: a physician, licensed behavioral health provider, nurse practitioner, nurse midwife, licensed midwife, enrolled doula, or community-based organization. Letters must be written within the last seven years. **One letter must be from either a licensed Provider, a community-based organization, or a DHCS enrolled doula**

Doulas must complete three hours of continuing education in maternal, perinatal, and/or infant care every three years. Doulas shall maintain evidence of completed training to be made available upon request.

Section F: Services Covered by Other Agencies

F1: Dental Services for Medi-Cal Members

Medi-Cal covers some dental services, including:

- Diagnostic and preventative dental hygiene (such as examinations, X-rays and teeth cleanings)
- Emergency services for pain control
- Tooth extractions
- Fillings
- Root canal treatments (anterior/posterior)
- Crowns (prefabricated/laboratory)
- Scaling and root planning
- Periodontal maintenance
- Complete and partial dentures
- Orthodontics for children who qualify

If members have any questions, want to learn more about dental services or want to find a dentist in your area, call Denti-Cal at 1-800-322-6384 (TTY 1-800-735-2922). You

may also visit the Denti-Cal website at https://www.dental.dhcs.ca.gov or https://smilecalifornia.org/

F2: Specialty Mental Health Services

County mental health plans (MHP's) are responsible for authorization and payment of a full continuum of specialty mental health services for CenCal Health members.

Medically necessary specialty mental health services include the following:

- Individual, family and group psychotherapy and rehabilitation services
- Medication support services
- Crisis intervention, stabilization, and residential services
- Targeted case management services
- Therapeutic Behavioral Services, Intensive Home-Based Services, Intensive Care Coordination and Therapeutic Foster Care for members under the age of 21.
- Psychiatric consultation in the Emergency Department
- Residential treatment, Partial Hospital Treatment or Intensive Outpatient services for a mental health, substance use or eating disorder.
- Electroconvulsive Therapy (ECT)

Medical Necessity

To qualify for specialty mental health services, adult members (over the age of 21) must be screened using CenCal Health'ss Level of Care screening and meet the range indicative of Specialty Mental Health Services.

CenCal Health children and youth under the age of 21 qualify for specialty mental health services under EPSDT if the services are "medically necessary."

Screening and Referral

Members who are screened on the Level of Care Screening and meet the criteria for County Specialty Mental Health Services, can be referred to the Behavioral Health Department to coordinate their referral to the County Department of Behavioral Health.
Providers should send the Level of Care Scoring indicating member meets SMHS/County criteria and the Transition of Care tool to the Behavioral Health Department via fax (805) 681-3070,or the Behavioral Health Department secure link.

The Behavioral Health Screening, Scoring, and Transition of Care Tools are located on the Behavioral Health Department provider website for download.

CenCal Contact Numbers

CenCal Health Behavioral Health Department

☎ Member Line: 1(877) 814-1861
Provider Line: (805) 562-1600
Fax number: (805)681-3070

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

Santa Barbara County Department of Behavioral Wellness

☎ Access Line (24/7) (888) 868-1649
Psychiatry Consultation Services: 1-805 681-5103

San Luis Obispo Department of Behavioral Health

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

F3: County Substance Use Services

Substance Use Treatment is provided by the County Alcohol and Drug Services for CenCal Members who meet medical necessity. The county provides a continuum of care for the treatment of substance use disorders modeled after the American Society of Addiction Medicine (ASAM) criteria. Covered services include:

- Withdrawal Management
- Intensive Outpatient & Outpatient services
- Opioid (Narcotic) Treatment Programs
- Recovery Services
- Case Management
- Perinatal & Non Perinatal Residential Substance Abuse services
- Out-patient therapy or medication services for a primary substance-use diagnosis.
- Residential treatment/Partial Hospital Treatment or Intensive Outpatient services for dual diagnosis, substance use disorders, or alcohol use disorders.

Referral

Members who are interested may contact the Behavioral Health Department directly to coordinate their referral at (877) 814-1861 or the County Access Line

☎ Santa Barbara County Department of Behavioral Wellness
Access Line (24/7) (888) 868-1649

☎ San Luis Obispo Department of Behavioral Health
Access Line (24/7) (800) 838-1381

CenCal Health Primary Care Providers and Mental Health providers who determine a member would benefit from Substance Use Treatment Services can submitting a Behavioral Health Care Coordination Referral to the Behavioral Health Department via fax (805) 681-3070, provider portal or the Behavioral Health Department secure link.

Reference Link:

Santa Barbara County Alcohol and Other Drugs Services
https://www.countyofsb.org/531/Alcohol-Other-Drugs

San Luis Obispo County

https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Drug-Alcohol-Services/Services/Drug-Medi-Cal-Outpatient-Delivery-System-(ODS).aspx

F4: Tri Counties Regional Center

Tri-Counties Regional Center (TCRC) is one of twenty-one non-profit Regional Centers in California providing lifelong services and supports for people with developmental disabilities residing in San Luis Obispo, Santa Barbara and Ventura Counties.

TCRC operates two separate programs, each with different eligibility rules.

1. The Early Start program is for infants birth to 36 months, who are at risk of developmental disabilities or who have a developmental disability. An infant or toddler (birth to 36 months) is eligible for Early Start if they have a developmental delay of 33% in one or more of the following areas of development: Social, Adaptive, Physical, Communication, and Cognitive. In addition, children with multiple medical factors that place them at risk for a developmental delay such as low birth weight, prematurity (less than 32 weeks), prenatal exposure to drugs, alcohol or teratogens, or if born with a condition with a known probability of causing a disability or delay such as Down Syndrome or other genetic conditions. Eligible children and their families may receive a variety of early intervention services including, but not limited to:
    - Infant stimulation (specialized instruction) in your home or community
    - Family resource Centers for parent-to-parent support.

2. The Regional Center general services program is for individuals older than 36 months who have a diagnosis of Autism, Epilepsy, Intellectual Disability, Cerebral Palsy, or a condition similar to Intellectual Disability that require treatment similar to a person with Intellectual Disability. In addition, their condition needs to be substantially handicapping and have begun before their 18th birthday. Once eligibility is established, services are available to the member for the duration of their life. Services may include but are not limited to:
    - Respite services
    - Independent Living Supports
    - Supported living services
    - Community Care facilities
    - Employment support
    - Safety supports i.e. tracking devices, crisis support services

CenCal Health Provision of Responsibilities

- CenCal Health is responsible for providing medically necessary BHT services as required by the Early and Periodic Screening, Diagnostic, and Treatment mandate, including coordination of a member's health care with the Regional Center to ensure non-duplication of services.
- CenCal Health is responsible for primary care and all other medically necessary services including comprehensive diagnostic evaluations.

- CenCal Health and its providers must ensure that they provide care coordination and necessary member information to the Regional Center as it relates to the identification of all medically necessary services or coordination of care issues, including the development of Individual Program Plans and Individualized Family Service Plans (IFSP).

Regional Center Provision of Responsibilities

- The Regional Center shall provide Targeted Case Management (TCM) services to eligible Members and their families to assure timely access to health, developmental, social, educational, and vocational services. Targeted Case Management services include:
- Coordination of services with CenCal Health to ensure non-duplication of services.
- Provision of referrals to specialty Centers and follow-up with schools, social workers and other agencies involved with the Member's care pursuant to the Individual Program Plan and the Individualized Family Service Plan (IFSP)
- Non-medical services not limited to, respite, out-of-home placement, and supportive living.

Referral

Members who are identified with conditions that are known to lead to developmental delays or those in who a developmental delay is suspected or whose early health history places them at risk of delay may be eligible to receive services from the Early Start program and may be referred by contacting the Regional Center to request an eligibility evaluation. The Regional Center evaluation process may take up to 90 days.

Members who are identified as having a developmental disability may be referred to the Regional Center for evaluation and for access to non-medical services provided by the Regional Center.

For more information regarding TCRC, please contact the specific county in which a CenCal Health member currently resides or please visit the Tri-Counties Regional Center website.

Santa Barbara County Offices:

☎ Santa Barbara: (805) 962-7881 or (800) 322-6994

FAX: (805) 884-7229

☎ Santa Maria: (805) 922-4640 or (800) 266-9071

FAX: (805) 922-4350

San Luis Obispo County Offices:

☎ San Luis Obispo: (805) 543-2833 or (800) 456-4153

FAX: (805) 543-8725

☎ Atascadero: (805) 461-7402

FAX: (805) 461-9479

Reference Link:
Tri-Counties Regional Center
https://www.tri-counties.org/

F5: Local Education Agency

A Local Education Agency (LEA) provides certain preventive, diagnostic, therapeutic, and rehabilitative services to eligible Members aged three (3) years and older who are identified as Children with Special Health Care Needs (CSHCN) while in school.
A Member may receive LEA services from their LEA in accordance with the Member's Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP).

LEA Services

LEA educational support services may include, but are not limited to, the following, when identified on the Member's IEP or IFSP.

- Health and mental health evaluation
- Health and nutritional assessment and education
- Developmental assessment
- Vision assessment
- Hearing assessment
- Education and psychosocial assessment
- Psychological and counseling services
- Nursing services
- School aid health services
- Specialized medical transportation services and the associated mileage and
- Therapy Services (OT, ST, ABA, Behavioral Therapy, Mental Health)

Identification and Referral of Members

- CenCal Health, LEA Practitioner or the Member's Primary Care Practitioner shall identify a Member eligible for LEA Services.
- Upon appropriate identification of a Member eligible for LEA services, CenCal Health, or the Member's PCP shall refer the Member to their LEA.
- A Member's PCP shall collaborate with the LEA to coordinate the provision of Medically Necessary services identified on the Member's IEP or IFSP.

Provision and Responsibility

- CenCal Health covers Medically Necessary mental health, Behavioral Health Treatment (BHT) and SUD services when delivered by school sites.

- CenCal provides case management and care coordination to the Member, or the parent, legal guardian, or authorized representative, to ensure the provision of all Medically Necessary Covered Services identified int eh IEP developed by the Local Educational Agency, with Primary Care Physician participation.

    1. Whenever the LEA services overlap with Early and Periodic Screening, Diagnosis, and Treatment services (EPSDT), CenCal Health and its Network:
        - Assess what level EPSDT Medically Necessary services the Member requires.
        - Determine what level of service (if any) is being provided by the LEA.
        - Coordinate the provisions with other entities, such as CenCal Health, to ensure such entities are not providing duplicative services, and that the child is receiving all Medically Necessary EPSDT services in a timely manner.
- CenCal Health has the primary responsibility to provide all Medically Necessary EPSDT services, including services which exceed the amount provided by the LEA.
- An LEA will never be considered the primary provider of Medically Necessary EPSDT services, as this is the responsibility of CenCal Health.

F6: Medi-Cal Rx – Medi-Cal's Pharmacy Benefit

Effective January 1, 2022, CenCal Health members Medi-Cal pharmacy benefit is through a new system. The Department of Health Care Services (DHCS) has given this new system the name, **Medi-Cal Rx**.

Medi-Cal Rx is administered through DHCS and its vendor, Magellan Medicaid Administration. Magellan provides a comprehensive suite of administrative services as directed by DHCS, which include claims management/adjudication, utilization management, and customer support.

Medi-Cal Rx is responsible for administering the following when billed by a pharmacy on a pharmacy claim form.

- Covered Outpatient Drugs, including Physician-Administered-Drugs (PADs)
- Medical Supplies
- Enteral Nutritional Products

Medi-Cal Rx does not include pharmacy services billed as a medical (professional) or institutional claim. Pharmacy services, including Physician-Administered-Drugs, billed on a medical claim is the responsibility of CenCal Health.

Information regarding Medi-Cal Rx formulary, prior authorization process, and provider portal can be accessed directly from the DHCS Medi-Cal Rx website.

Medi-Cal Rx customer service center can be reached directly at 1-800-977-2273

The CenCal Health Pharmacy Team is also available to answer any questions regarding Medi-Cal Rx at 805-562-1080

Reference Link:
DHCS – Medi-Cal Rx:
https://medi-calrx.dhcs.ca.gov/home

CenCal Health Pharmacy Services:
https://www.cencalhealth.org/providers/pharmacy/

Section G: Eligibility Verification and Enrollment

G1: Eligibility Frequently Asked Questions (FAQ)

CenCal Health currently serves approximately 227,000 residents in our service area of Santa Barbara and San Luis Obispo counties.

Does CenCal Health Determine Member Eligibility for its Medi-Cal (SBHI & SLOHI) Members?
No, the Department of Social Services (DSS) and/or each counties Social Security Administration determine SBHI and SLOHI eligibility.

CenCal Health's Member Services Department provides:

- Understanding how the Health Plan works
- Selecting a Primary Care Provider (PCP)
- Finding a specialist
- Benefit education
- Filing a complaint or appeal
- Arranging interpreter services

- Scheduling appointments
- Replacing Health Plan identification cards
- Transportation needs for those members that qualify
- Translation and Alternative Format Services

REMINDER: Always verify a member's eligibility status prior to treatment!
All providers are urged to verify member eligibility and PCP assignment (or Special Class status) prior to rendering services. This will serve to:

- Reinforce case management
- Avoid possible referral/authorization/claims problems
- Identify instances of member misrepresentation

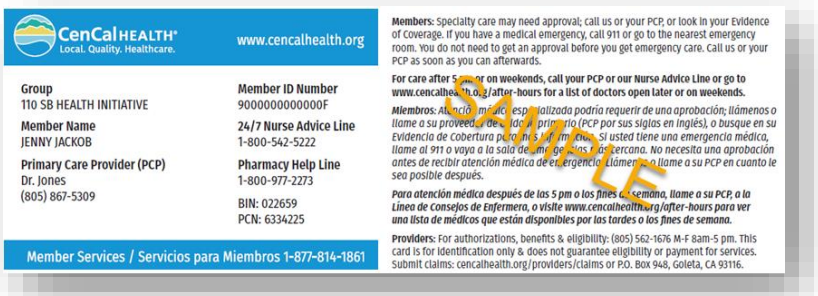
Who are Medi-Cal (SBHI & SLOHI) Special Class Members?
Any SBHI/SLOHI contracted provider who is willing, can see members who are Special Class. Special Class Members are considered fee-for-service and are

assigned to CenCal Health; therefore, they do not require Referral Authorization Forms (RAFs), though they may require a Prior Authorization Request when appropriate.
Categories for Special Class include:

- The first month of eligibility
- Members that reside in long-term care facilities (skilled nursing or institutions for the developmentally disabled)
- Members who have met their share-of-cost
- Members in hospice
- Members that reside out of county
- Members that are qualified under the Genetically Handicapped Persons Program

Are CenCal Health members issued ID cards?
Yes, CenCal Health members receive an Identification Card, as shown below. The group lists the program under which the member is covered.

Other information printed on the card includes member name, ID number, PCP name and PCP phone number. These cards are issued only once, and are reissued only when information on the card changes. These cards are intended only to be a means of identification. They are not considered proof of eligibility.



The State also issues a permanent, plastic ID card for all Medi-Cal members called the "Benefits Identification Card" or BIC. Currently there are two versions of the BIC that members may present (see examples below).

The BIC is a permanent card, which does not provide proof of eligibility. Providers must verify eligibility information using the information on this card through one of the various options made available.

How do I verify member eligibility?
Providers can access CenCal Health eligibility information using two options.

Option 1: Via CenCal Health Website: www.cencalhealth.org
You can verify eligibility for CenCal Health members as well as State Medi-Cal members through our website. First, the provider must have an active web account. To create a web account, contact providerservices@cencalhealth.org. Once you are logged into the restricted 'For Providers' section, click the Eligibility tab on the left hand side, enter the CenCal Health Member ID and date of service. If the member is not eligible through CenCal Health, you have the option to check with DHCS for further eligibility information.

Option 2: Via CenCal Health's Member Services Department: Toll Free Number (877) 814-1861, select option 3. A representative of the Member Services Department can provide information for CenCal Health eligible members. Be prepared to give your provider's identification number (NPI).

Medi-Cal Eligibility Verification options available through the State
Note: Options for eligibility verification currently made available by the State do not take into account the need for SBHI and SLOHI providers to verify a member's PCP. PCP affiliation is important, as Referral Authorization Forms (RAFs) from the PCP are needed for most specialty services.

Automated Eligibility Verification Service (AEVS)
AEVS (800) 456-2387 is a free telephone service provided by the State for Medi-Cal providers. AEVS requires the use of your Provider Identification Number (PIN).

What are Aid Codes?
An aid code is the two digit alphanumeric number, which is used to assist in identifying the types of services for which Medi-Cal recipients are eligible.

What if I see a Medi-Cal member that is not SBHI or SLOHI?
CenCal Health is a State contracted Medi-Cal Managed Care plan which delivers care in San Luis Obispo and Santa Barbara counties. If a member resides in a different county, they may be eligible with another County Managed Care plan. Please check with the Managed Care plan in the county the member resides for eligibility and guidelines. If the member is eligible with State Medi-Cal, you can bill Affiliated Computer Systems (ACS) following State Medi-Cal guidelines.

Is a CenCal Health member eligible to see a doctor out of county?
If a member is outside of the health plan's service area (Santa Barbara and San Luis Obispo Counties) and needs medical services, they are instructed to call their PCP unless it is an emergency or urgent situation. If it is an emergency or urgent situation, they may go to the nearest urgent care facility, emergency room or call 911. For non-urgent issues, a member's PCP must authorize (with a RAF) any medical care. It is the Provider's responsibility to check eligibility and obtain a RAF from the assigned PCP. Providers must be Medi-Cal* certified in order to be reimbursed.
**Out of State providers need to be Medicaid certified.*

G2: Share of Cost (SOC) Frequently Asked Questions (FAQ)

What is Share of Cost?
Share of Cost (SOC) is a monthly dollar amount, which a patient is required to pay before he/she becomes eligible with Medi-Cal. The SOC amount is based on the income information supplied by the patient to his/her Eligibility Worker at the Department of Social Services.

CenCal Health is not involved with determining SOC or eligibility.
(Note: If the member does not have any medical expenses for a particular month, no SOC is paid)

Is a Share of Cost (SOC) a Co-Pay?
No, a Medi-Cal recipient's SOC is similar to a private insurance plan's out-of-pocket deductible. This SOC is monthly and is based on the amount of income a recipient receives in excess of "maintenance need" levels (determined by the State). Medi-Cal rules require that recipients pay income in excess of their "maintenance need" level toward their own medical bills before Medi-Cal begins to pay.

To whom does the member pay a SOC payment?
A patient can pay or make a payment plan for his/her SOC with any Medi-Cal provider.

SOC can also be met with providers who are not Medi-Cal certified. In this case, the member must get a receipt with the following information: provider name pre-printed company letterhead, procedure code, date of service, and total amount paid. The patient must take this to his/her Eligibility Worker to have the paid amount applied towards their SOC. Additionally, the patient can pay providers who are not medical providers (such as dentists) or pay for services which are not normally Medi-Cal benefits such as non-formulary medications and circumcisions.

What does "payment plan" mean?
If a patient cannot pay the total SOC amount or has a large SOC and needs to make payments, the patient can make a payment plan with the provider; this is sometimes call obligating the SOC. The payment arrangements will be entirely between the patient and the provider. CenCal Health does suggest that this agreement be in writing.

Important: When arrangements are made to accept payments for SOC amount owed the entire SOC amount owed should be cleared immediately. Providers should never wait to clear the SOC until the entire amount is paid. This may keep the patient from obtaining other medical services if needed.

SOC patients are considered 'cash pay' patients until their SOC is met for a particular month. If the member does not fulfill an obligation, your office policy for "nonpayment" can apply. CenCal Health is not responsible and cannot be billed.

When does a SOC patient become Medi-Cal eligible?
When the patient meets their monthly SOC and the provider clears the SOC amount as described below.

What does "meeting share of cost" mean?
This means a patient's total SOC amount is paid.

What does "spending down SOC" mean?
This means the provider has applied or cleared SOC with the State.

How do I apply or clear SOC?
Providers collect payments from the patient or accept the patient's payment plan to pay for services that are rendered up to this SOC amount. Providers should immediately submit a SOC clearance transaction to the State using either of the methods below.

State Medi-Cal Website Clearance: http://www.medi-cal.ca.gov/mcwebpub/login.aspx
Must have a Medi-Cal provider number, PIN number and have a Medi-Cal Point of Service (POS) Network/Internet Agreement form on file. For information on Provider Enrollment, visit the Provider Enrollment page https://files.medi-cal.ca.gov/pubsdoco/prov_enroll.aspx

Please call the Telephone Service Center (TSC) at (800) 541-5555 for more information. A provider's failure to clear the patient's SOC immediately may prevent the patient from receiving necessary services or medicine, despite having fulfilled the SOC obligation.

(Remember, the State, not CenCal Health clears the SOC. Although CenCal Health has the ability to transmit this information to the State, records are not kept in our database. We strongly suggest that you print out the information and place in the member's file.)

Why does a patient's SOC amount change?
Depending upon fluctuations in the patient's monthly income, SOC amounts may change from month to month. Additionally, if a patients' SOC is partially met by multiple providers, different 'remaining' SOC amounts will appear during eligibility verification, until the total SOC is satisfied for that month. CenCal Health strongly suggests verifying eligibility at every visit to get updated SOC information.

Do SOC recipients have PCPs?
No, the recipient will not have a PCP. Once a patient meets the total SOC obligation, they will become an SBHI/SLOHI member and will be classified as "Special Class" (not case managed). The member's PCP will appear as "CenCal Health" when verifying eligibility.

What is an LTC SOC?

This type of SOC is associated with a Long-Term Care (LTC) Facility. This SOC is paid to the nursing facility by the patient before the LTC can send a claim to Medi-Cal for the remaining difference. This SOC is always handled by the LTC on their monthly billing; other medical providers are not affected. If you are not an LTC provider, do not charge a SOC to the patient who resides in an LTC.

Do I need to submit a TAR for approval if the patient has a SOC?
If the total SOC amount will not cover the full-billed charges and the SBHI/SLOHI allowable payment for the provider would be higher than the SOC amount, providers should follow the usual procedures for TAR approval. This authorization and a cleared SOC will allow you to bill CenCal Health the difference.

Example: Member has a SOC of $50.00. The billed charges for the TAR required procedure are $250.00. SBHI/SLOHI allowable is $150.00. You will need to submit a TAR for authorization, spend down the SOC and after TAR is approved, and member is eligible with SBHI/SLOHI, bill SBHI for the remaining balance owed. SBHI/SLOHI pays up to the allowable, minus the SOC payment.

Do I submit a claim for a SOC patient?
If the patient's SOC equals or exceeds your total charges, do not submit a claim to CenCal Health. The paid/obligated SOC is considered the full payment and CenCal Health will not pay more than that amount.

Only when the SOC payment you receive is less than the SBHI/SLOHI/Medi-Cal allowable and the patient's SOC has been met, making them eligible, then there will be additional payment consideration. If you do submit a claim, you will need to enter the SOC information (see "Where do I put the SOC information" below).

Where do I put the SOC information on the claim?
Medical & Allied Health Providers
On the CMS 1500, claim forms enter the "claim codes" in box 10D and amount paid in Box 29.

For providers who bill on UB-04 Claim Forms
On the UB-04, claim forms enter the amount paid in Box 39-41 (value codes amount).

Section H: Referrals and Authorizations

H1: Medically Necessary (or Medical Necessity) Services

Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as

required by W&I Code sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Services, products, therapies that are a covered benefit of CenCal Health, including those services that exceed the services provided by Local Educational Agencies (LEA), Regional Centers (RC) or local governmental agencies and determined to be:

- Appropriate and necessary to diagnose a condition or to treat the symptoms, diagnosis, illness, or injury.
- In accordance with evidence-based, professional, and nationally recognized clinical criteria, approved by CenCal Health And developed with practicing health care providers that is updated when necessary and at least annually.
- Not primarily for the convenience of the member, or the member's physician or other Provider.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services, in accordance with the parity in mental health and substance use disorder requirements in 42 CFR section 438.900, et seq.

CenCal is not responsible for the review of Prior Authorizations for Physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient drug claims billed on a pharmacy claim by an outpatient pharmacy. *References: Title 22 CCR, Section 51303(a), CenCal Contract 08-85212, Exhibit E, Attachment 1, and CenCal Policy- Separation of Medical and Financial Decision Making (MM-UM24)*

H2: Sensitive Services

All members have the right to confidentiality when receiving sensitive services or family planning services. If the member is a minor under age eighteen, they do not need the consent of their parent or guardian to receive these services. Members may obtain these services with their Primary Care Physician or directly with any qualified Medi-Cal provider within or outside of the health plan or provider network. Members do not need a referral from their Primary Care Physician.

Sensitive services include:

- Pregnancy testing and counseling
- Birth control
- AIDS/HIV testing
- Sexually transmitted disease testing and treatment
- Abortion (ending pregnancy) services and counseling

- Drug and alcohol abuse services and counseling
- Outpatient mental health services and counseling
- Sexual assault services

Family planning services include:

- Birth control (most require a prescription), including:
  - Birth control pills
  - Condoms
  - Contraceptive implant
  - Diaphragm or cervical cap
  - Depo Provera shot
  - Emergency birth control (also called the morning after pill)
  - Female condom
  - Intra-uterine device (IUD)
  - Spermicides
  - Sterilization (tubal ligation and vasectomy)
- Pregnancy testing
- Pregnancy counseling

Primary Care Physicians, County clinics, family planning providers, gynecologists, mental health providers, obstetricians, or multi-specialty groups can provide sensitive services. Please refer to your Contracted Provider Listing for a listing of providers.

H3: Request for Authorization

Providers may submit prior authorization requests via the Provider Portal. Alternatively, providers may choose to fax a completed prior authorization form (RAF, 50-1, 20-1, 18-1) to the Utilization Management Department at (805) 681-3071.

Please refer to Section H to determine which form (RAF, 50-1, 20-1 or 18-1) to use when submitting your request. In general, the services listed below require prior authorization from CenCal Health before rendering services:

- Psychological & Neuropsychological Testing
- Behavioral Health Treatment services (BHT) including ABA services
- Scheduled (elective) surgery
- Non-emergent medical transportation (NEMT)
- Non-emergent inpatient admissions, including Acute Inpatient and Rehab, Skilled Nursing Facilities (SNF), Congregate Living Health Facility (CLHF), Subacute Care, Long-Term Acute Care (LTAC)
- Hearing aid(s)
- DME
- Orthotics
  - Therapeutic diabetic shoes and inserts always require prior authorization
- Prosthetics
- Home Health services (nursing, OT, Speech and; PT)

- Outpatient Therapy (OT, Speech, PT after first 18 visits)
- Home Infusion therapy
- Genetic testing
- Services with unlisted/miscellaneous procedure codes
- Wound care and medical supplies
- Non-participating, non-contracted, and out-of-network providers, including tertiary care facilities
- **Radiology and Imaging Services**, such as CT, CTA, MRI, MRA, PET, PET/CT, Nuclear Med
    - Submit your request to Care to Care via:
        - Phone (888) 318-0276 (Call Center is open Mon-Fri, 5:00am – 5:00pm)
        - Fax (888) 717-9660
        - Care to Care's Portal at https://cencal.careportal.com/

To determine if a proposed treatment, therapy, procedure, or service code requires a prior authorization, please use our Procedure Code Look Up

Reference Link:
HCPC/CPT Procedure Code – Prior Authorization Requirement Search Tool
https://procedureauth.cencalhealth.org/

H4: Referral Authorization Form (RAF) Exceptions

Referral Authorization Form (RAF) is required for all case managed CenCal Health members; however, there are a few exceptions to this rule.

Services that are exempt from the RAF requirement:

- Special Class Members
- Sensitive Services (Family planning, sexually transmitted diseases appointments, abortion and HIV testing)
- Emergency Service
- Mental Health psychotherapy
- Mental Health Medication Management Services
- Psychological and Neuropsychological Testing for an underlying Mental Health condition.

Please reference the Authorization section of our website for more information.

Reference Link:
CenCal Health Referral Authorization Process
www.cencalhealth.org/providers/authorizations/referrals/

H5: Medi-Reservations

"Medi-Reservation" shall mean a method of limiting the Medi-Services (or "Limited Services") allowed under the Medi-Cal program, whereby a Member is entitled only to two visits or services per month.

Medi-Reservation – SBHI & SLOHI Members

Services must be reserved by Providers for each visit to be provided. Services may be reserved by completing and submitting the Medi-Reservation Form found on the CenCal Health website. A confirmation number will be given once the Service is reserved.

Services Requiring a Medi Reservation:

- Audiology
- Chiropractic
- Acupuncture

Please check When RAF's Are Not Required on our website to determine whether a RAF is required. For more information about Medi-Reservations, please visit the Medi-Cal website.

Reference Link:
DHCS Medi-Cal Provider
www.medi-cal.ca.gov/

H6: Decision-Making Guidelines

CenCal Health uses the Department of Health Care Services, **Medi-Cal Program's** coverage guidelines t. CenCal Health uses licensed **Milliman Care Guidelines (MCG)** to review authorizations against evidenced based clinical care guidelines. When none of the above sources have clear and concise guidelines, CenCal Health will research, utilize, and as needed, adopt clinical guidelines established by nationally recognized organizations and health plans that are based on sound clinical evidence for decision-making. Decisions to deny or to authorize an amount, duration, or scope that is less than requested are made by a qualified health care professional with appropriate clinical expertise in the medical or behavioral health condition and disease or Long-Term Services and Supports (LTSS) needs.

The Plan reserves the right to use a board certified specialist and/or an external review organization to assist in decision-making.

For your convenience, below are guideline links to frequently requested services:

DHCS Durable Medical Equipment (DME): Oxygen and Respiratory Equipment (dura oxy)
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duraoxy.pdf

DHCS Audiology and Hearing Aids (AUD)
https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=*_*a00*+OR+*_*a02*+OR+*_*z00*+OR+*_*z02*&wFLogo=Part2+%23+Audiology+and+Hearing+Aids+(AUD)&wPath=N

DHCS Orthotics and Prosthetics (OAP)
https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=*_*a00*+OR+*_*a06*+OR+*_*z00*+OR+*_*z02*&wFLogo=Part2+%23+Orthotics+and+Prosthetics+(OAP)&wPath=N

DHCS Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories (dura bil wheel)
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durabilwheel.pdf

H7: Timeliness for Authorization Request

Providers are encouraged to submit authorization requests for services in a timely manner and preferably via the Provider Portal . Physician Reviewers who hold an active, unrestricted California license make medical decisions. Notice of Action or Notice of Adverse Benefit Determination (Approval, Denial or Modification Determinations) are sent to the Provider via fax, email or mail. Members will receive their Notice of Action or Notice of Adverse Benefit Determination via U.S. mail within 2 working days of the decision. Notices to approve or deny an urgent request will be verbally communicated, electronically emailed via Provider Portal, or faxed to the requesting Provider and/or the member at the time the decision is rendered followed by written notice of a denial determination to the Provider and the member within two business days.

Routine (Standard) Request

CenCal Health shall make best efforts to process prior authorization requests promptly. CenCal Health will consult with Providers as needed for Prior Authorization requests for the purposes of determining Medical Necessity for medical services unless doing so would lead to undue delay in care. Decisions for a routine prior authorization request are usually made within 5- business days of receipt of referral. The decision may be extended up to 14 days from receipt of request. The decision may be deferred and the above time limit extended an additional 14 calendar days when additional clinical information is needed for review and when the member, member's requesting provider or CenCal Health can justify that an extension would be in the best interest of the member.

Urgent (Expedited) Authorization Request

An urgent authorization request is appropriate when a provider indicates or CenCal Health determines, that following the routine timeline could seriously jeopardize the enrollees life or health or ability to attain, maintain or regain maximum function. Urgent prior authorization requests will be processed within 72 hours of CenCal Health's receipt of the request unless additional information is required.

A retroactive authorization request is not considered urgent.

Reference: Health Plan contract 08-85212, Exhibit A, Attachment 5-Utilization Management

Urgently Needed Services/Urgent care – Covered services for conditions that are not life- threatening but could result in serious injury or disability to the member unless medical attention is received. Urgent care means an episodic physical or mental condition perceived by a member as serious but not life threatening that

disrupts normal activities of daily living and requires assessment by a healthcare provider and if necessary, treatment within 24-72 hours. Some examples include:

- Accidents and falls
- Sprains and strains
- Moderate back problems
- Breathing difficulties (i.e. mild to moderate asthma)
- Bleeding/cuts -- not bleeding a lot but requiring stitches
- Diagnostic services, including X-rays and laboratory tests
- Eye irritation and redness
- Fever or flu
- Vomiting, diarrhea or dehydration
- Severe sore throat or cough
- Minor broken bones and fractures (i.e. fingers, toes)
- Skin rashes and infections
- Urinary tract infections

Emergency Services
Emergency services are in-patient and outpatient covered services that are rendered by a provider that is qualified to provide those health services needed to evaluate or stabilize an Emergency Medical Condition. **NO AUTHORIZATION REQUIRED.**

Non-Urgent Care Following an Exam in the Emergency Room: CenCal Health will respond to a Provider's request for post-stabilization services within 30 minutes or the service is deemed approved.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably expect to result in any of the following:

- Placing the patient's health (or in the case of pregnant woman, the health of the woman or unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or part.

Reference: CenCal contract 08-85212, Exhibit E, Attachment 1-Definitions

Hospital Emergency Services: In the case of an emergency medical condition, hospitals are not required to obtain prior authorization from the Plan prior to providing emergency services to members; provided, however, that upon admitting a member into hospital, the hospital should notify the Plan no later than the next business day from the date of admission. The hospital can submit a 18-1 via Provider Portal or fax an admission face sheet to CenCal Health via fax at (805) 681-3071.

Except for emergency services, coverage of all services rendered to members by the hospital is subject to CenCal Health's determination of whether such service is a covered under the applicable member benefit package. In the event it is determined that an emergency medical condition does not exist with respect to a member who presented to the hospital, the hospital needs to comply with all prior authorization requirements as set forth in this manual prior to providing any non-emergency services to a member.
Hospital's failure to obtain all required prior authorizations for non-emergency services may, in the Plan's sole discretion, result in the Plan's denial of payment for such services. Hospital shall comply with this manual and the agreement in providing non-emergency services to members. Hospital acknowledges and agrees that the Plan has the right to review the admission of any member for an emergency medical condition for appropriateness of continued stay.

Post-Stabilization: CenCal Health will respond to a Provider's request for authorization for post-stabilization services within 30 minutes or the service is deemed approved in accordance with 22 CCR section 53855(a).

Retrospective Authorization Request for Treatment Received: CenCal Health accepts retrospective authorizations up to 365 calendar days from the date of service. CenCal Health will provide a determination within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S Code section 1367.01(h)(1).

H8: Hospital Discharge Follow-Up Care

CenCal Health provides Transitional Care Services to all Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and state laws and regulations, and DHCS guidance.

Hospital shall coordinate discharge follow up services for the member in a prompt and efficient manner. Hospital shall at all times promptly and openly communicate with the member's PCP regarding the member's medical condition, including without limitation, obtaining the appropriate prior authorization should a member require additional or follow-up covered services. CenCal Health contracted Providers, and Hospitals, shall ensure that prior authorizations required for the Member's discharge are submitted in accordance with Utilization Management turnaround times.

Please see reference Section I4: Care Transition of the Provider Manual for more information.

H9: Referrals for Specialist Services

Except for emergent, urgently needed services, or Mental Health services; or as otherwise noted in this Manual, applicable member's benefit package, or applicable State or Federal laws; specialist shall not provide specialist services to members when there is no existing PCP referral to the specialist. The PCP needs to complete a Referral Authorization Form (RAF) via Provider Portal, fax, or secure link at when specialist care is needed for a member.

Please reference Section E7 Mental Health Services of the Provider Manual for more information.

H10: Follow-Up Specialist Services

Specialist shall coordinate the provision of specialist services with the member's PCP in a prompt and efficient manner and, except in the case of an emergency medical condition, shall not provide any follow-up or additional specialist services to members other than the services indicated, duration and frequency indicated on the RAF provided to specialist by the Plan or the PCP.

Within ten (10) business days of providing specialist services to a member, specialist shall provide the member's PCP with a written report regarding the member's medical condition in such form and detail reasonably acceptable to the member's PCP and the Plan. Specialist shall at all times promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation obtaining the appropriate pre-authorization should a member require additional or follow-up covered services beyond those indicated on the RAF.

Except in the case of emergency or urgently needed services, specialist shall refer members back to the member's PCP in the event the specialist determines the member requires the services of another specialist physician.

H11: Out of Network Services

Any non-emergent or non-urgent services rendered by non-participating, non-contracted providers or facilities must be prior authorized by CenCal Health and must meet the member's medical need for specialized or unique services which the Plan considers unavailable within the existing network. The requesting provider needs to complete and submit a Referral Authorization Form (RAF) to CenCal Health for review. If CenCal Health approves the member to go out of network, the cost to the member is not greater than it would be if the service was provided in-network.

H12: Second Opinions

Members have access to a second medical opinion in any instance in which the member questions the reasonableness or necessity of the recommended procedure or questions a diagnosis or plan of care for a condition that threatens

loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.

CenCal Health will allow a second opinion from a qualified health professional if available. If the member selects a contracting provider/specialist, the PCP may enter a RAF via Provider Portal or fax a completed RAF to CenCal Health to process the second opinion. If a qualified health professional within the Network is not available, CenCal will authorize an out of network provider to provide the second opinion at no cost to the member, in accordance with 42 CFR section 438.206. The PCP will submit a RAF via the Provider Portal, secure link or fax to CenCal Health.

H13: New Medical Technologies

CenCal Health evaluates the necessity of coverage for new medical technologies or new applications of existing technologies on an ongoing basis. These technologies may include medical procedures, drugs and devices. The following factors are considered when evaluating the proposed technology:

- Input and coverage guidance from appropriate regulatory agencies.
- Scientific evidence that supports the technology's positive effect on health outcomes.
- The technology's effect on net health outcomes as it compares to current technology.

H14: Continuity of Care

To ensure continuity of care for members transitioning to CenCal Health coverage and are receiving services during a acute condition, serious chronic condition, pregnancy, chronic mental health condition, terminal illness, care of a newborn child, or previously authorized surgery or other procedure from out-of-network providers.

Providers may request continuity of care on behalf of the Member or the member may make that request themselves by contacting Member Services.
CenCal Health members may request continuity of care with any out of network provider with whom the Member has had a pre-existing relationship with or the provider has terminated their contract with CenCal Health. The member must have seen the provider within the past 12 months or 6 months for Behavioral Health Treatment services.

H15: Attachment A – Authorization Guide

Form	Type of Request or Service	Who Can Submit the Request?	Purpose	Processing Timelines for URGENT Request	Processing Timelines for Routine Request

Referral Authorization Form (RAF)	Referral from PCP to Specialist, for a Second Opinion, or Standing Referral for extended care	PCP (and occasionally, designated Provider Service Staff)	To determine the medical necessity of a referral to a specialist, tertiary care center or out of network provider.	no later than 72 hours * from the receipt of referral request	within 5 working days but up to 14 calendar days*
Behavioral Health Referral (RAFB)	Referral from a qualified provider) for Behavioral Health Treatment (ABA) services	Physician, Psychologist or Surgeon	To refer the member for Behavioral Health Treatment (ABA) services.	no later than 72 hours * from the receipt of referral request	within 5 working days but up to 14 calendar days*
Treatment Authorization Request (TAR) Located below are three (3) different TAR form types					
50-1	Procedures, DME, Hospice, Home Health, Outpatient mental health, Behavioral Health Treatment, **Elective** admission request	The provider of service, e.g., DME vendor, Home Health agency. **ALERT: Make sure MD has signed the order.**	To determine the medical necessity of a requested service.	no later than 72 hours * from the receipt of request for service	within 5 working days but up to 14 calendar days*
18-1	Inpatient: acute, LTAC, Rehab. Concurrent	Admitting hospital or LTAC facility	To determine the medical necessity of continued acute care and to facilitate a transfer/transition of care	within 24 hours of admission notification and receipt of supporting clinical documentation or concurrent review (denial or modification, e.g., lower level of care), notify the treating provider/facility	
20-1	SNF, Subacute, CLHF	Admitting facility, hospital discharging member, PCP for	To determine the medical necessity of continued stay in skilled nursing facilities (SNF),	within 24 hours of admission notification, receipt of supporting clinical documentation and based on subsequent concurrent	

		Community to SNF Placements	subacute, and congregate living health facilities (CLHF)	review timelines (denial or modification, e.g., lower level of care), notify the treating provider/facility

*Can extend up to an additional 14 calendar days with an issuance of a NOA "delay".

Section I: Care Management Programs and Community Support Services

I1: Utilization Management

Our Utilization Management Program is overseen by the Chief Medical Officer, Medical Directors responsible for the utilization review process and qualified health services staff. Our Utilization Management Program helps members to get the best quality healthcare by assuring that medically necessary healthcare services are provided at the right time and at the most appropriate service level or care setting covered under their benefit package. We work with our providers to evaluate services for medical appropriateness and timeliness.

- Authorization decisions are made on Medical Necessity of a requested health care services and are consistent with criteria or guidelines supported by clinical principles and evidenced based.
- We do not pay, offer financial incentives, or reward our providers, employees or other individuals for utilization management decisions.
- CenCal Health's Policy and Procedures for authorization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
- CenCal Health makes available all relevant Utilization Management policies and procedures upon request
- Utilization Management activities are integrated into the Quality Improvement Systems to review requests, denials, deferrals, modifications, appeals and grievances to the medical director.
- CenCal Health maintains timelines and process that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Limitations (NQTL) more stringently in mental health or substance use disorder services than are imposed on medical/surgical services.

I2: Enhanced Care Management

Effective July 1, 2022, CenCal Health offers Enhanced Care Management (ECM) a new statewide Medi-Cal benefit available to selected "Populations of Focus" as part of CalAim's multi year initiatives. ECM is designed to address the clinical and non-clinical needs of the highest-need Members through intensive whole person care coordination. ECM has a phased implementation approach based on Department of Health Care Services defined Populations of Focus (POF).

Phase 1: 7/1/2022

- Individuals & Families Experiencing Homelessness (POF 1)
- Adults At Risk for Avoidable Hospital and Emergency Department (ED) Utilization (POF 2)
- Adults with SMI/SUD Needs (POF 3)

Phase 2: 1/1/2023

- Adults Living in the Community At Risk for Institutionalization (POF 5)
- Adults who are Nursing Facility Residents Transitioning to the Community (POF 6)

Phase 3: 7/1/2023

- Individuals Transitioning from Incarceration (POF 4)
- Children & Youth Populations of Focus (POF 7)

Phase 4: 1/1/2024

- Pregnant and Postpartum Individuals At Risk for Adverse Perinatal Outcomes (POF 8)

Members who are eligible for ECM are assigned to an ECM provider who has the expertise in serving the various populations of focus and will provide Outreach to engage member to enroll in the program. Members who agree to participate in ECM will be assigned a Lead Care Manager who will meet the member wherever they are (e.g., Street, Shelter, Skilled Nursing Facility) and who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for Members to get the right care at the right time.

The ECM provider will offer the following seven (7) ECM core components

- Outreach and Engagement
- Comprehensive Assessment and Care Management Planning
- Enhanced Coordination of Care
- Health Promotion Activities
- Comprehensive Transitional Care Planning
- Member and Family Supports
- Coordination of and Referral to Community and Support Services

Primary Care Providers (PCP) are an integral part of the member's care coordination team and will be notified when an ECM eligible member has been enrolled in the ECM program. The notification will include name and contact information of the member's assigned ECM provider.

Referring Members to Enhanced Care Management

Providers are welcome to refer members who may benefit from ECM. ECM Referrals can also be submitted by but not limited to members or their Authorized Representatives, Community and Government agencies. To submit a referral request for ECM, Click here, or call our Member Services Department at 1-877-814-1861. We ask that you please allow ten (10) business days to determine eligibility and assign an ECM provider for Member Outreach.

To learn more about ECM please click here
www.cencalhealth.org/providers/calaim/

I3: Care Management (Complex and Care Coordination)

CenCal Health's care management programs support members with the appropriate level of care management through person-centered interventions and individualized care plans based on the intensity of health and social needs and services required. Assessments are completed to ensure members who are identified as having medical, behavioral, oral, Long Term Services and Supports and social determinants of health needs receive the necessary services to gain optimum health.

CenCal Health has five variations of care management services:

- Enhanced Care Management (ECM)
- Case Management (Complex and Care Coordination)
- Care Transitions
- Pediatric Whole Child Program
- Disease Management Program

Each of the Care management services promote quality care and cost-effective outcomes that enhance physical, psychosocial, and vocational heath of individuals. It includes on going assessing of needs, planning, implementing, coordinating, and evaluating health-related service options. Members may self-refer to the Care Management programs. Referrals can also come from a variety of sources, such as the PCP, Specialist Physician, Utilization Management team members, Medical Director, member/family, internal departments, and community based organizations. Providers may request assistance in the development of care plans for the treatment of members with complex or serious medical conditions.

To learn more about ECM please see the CalAIM section of our website
cencalhealth.org/providers/calaim/

To refer a member to any of our Care Management Programs, providers can complete and submit a Case Management Referral Form located at cencalhealth.org/providers/calaim/.

The completed referral form may be faxed to (805) 681-8260 or the provider can call the Health Services Central Line at (805) 562-1082, option # 2 to obtain assistance with referring a member.

The Case Management Department will acknowledge referral and providers will be informed of the member's appropriateness for CM services. Once CM determines a member is appropriate for case management services and the member or authorized representative agrees to the service, CM will begin to work collaboratively with the member, the member's family, physician(s), and other healthcare professional(s).

Reference Link:
Case Management Referral Form
https://www.cencalhealth.org/providers/case-management/

Care Management
CenCal Health Care Management ensure that the needs of member are met across the continuum of care. Members are provided appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. Coordination of care is done collaboratively with member and their PCP, specialists and other members of the interdisciplinary team. Coordination of care also includes coordinating health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of CenCal Health's Provider Network, and with Community Supports and other community-based resources, even if they are not Covered Services under CenCal Health , to address Members' needs and to mitigate impacts of Social Determinants of Health .

Referrals to Care Management
Members may be eligible for Care management Services if they meet one of the following criteria:

- Have complex or chronic medical conditions, including those affecting multiple organ systems or complicated therapy that warrant closer monitoring (e.g. CHF, uncontrolled diabetes, transplants, cancer, exacerbating asthma, ESRD or COPD),
- Have suffered a traumatic/ catastrophic injury or illness.
- Is non-adherent to medical or treatment regimen (e.g., two or more missed appointments, misuse of medications, poor dietary adherence).
- Are high utilizers of EDs (e.g., two visits in three months).
- Over/under utilize medical services that are available to them.
- Have frequent hospital admissions (same or different diagnosis) and readmissions. (within thirty days of discharge) for ambulatory care sensitive conditions such as diabetes, asthma, congestive heart failure, hypertension (e.g., four hospital admissions in one year).
- Need coordination of care for medically necessary services outside of the provider network.
- Require assistance following a particular medical regimen (e.g., pre-surgical).

Have self-care deficits requiring one-to-one or group health education to promote well- being.
- Have high psychosocial risk factors that have or can result in significant negative health outcomes.
- Assistance with coordination to community resources (e.g. Food Bank, Meals on Wheels, Family resource Centers, and/or Unity Shop)
- Members with fragile conditions, including cognitive changes needing assistance with care coordination or care transitions.
- Require care coordination with specialized programs, such as Local Education Agency, Regional Centers and County Mental Health.
- Members who need transition from one care setting to another (e.g. from acute care facility to skilled nursing facility (SNF), SNF to home or other alternative living situations, home to SNF, and non-contracted to Contracted SNF)

CenCal Health's Care Management (CM) services are provided by Care Managers that consist of registered nurses, social workers, and clinical support associates via telephone. Care Management services are offered available to all members, both adult and pediatric members. Care management programs vary depending on the needs of the member. Please reference Section I2 Enhanced Care Management of the Provider Manual for more information.
CenCal Health's Case Management program includes:

- Conducting Member Assessments to identify and close any gaps in care and address the Member's physical, mental health, SUD, developmental, oral health, dementia, palliative care, chronic disease and LTSS needs as well as needs to SDOH.
- Complete a person centered care management plan for all members in consultation with the member to include addressing the members health and social needs including needs due to SDOH.
- Support and ensure access to all needed services and resources across physical and behavioral health systems.
- Provide referrals to community based social services and other resources outside of Member's MediCal benefits.
- Ensure continuous information sharing and communication with the Member and treating providers.
- Ensure Members receive all Medically Necessary services, including Community Supports to close any gaps in care and address the Member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH.
- Provide Closed Loop Referrals to Community Health Workers, peer counselors, and other community based social services.
- Facilitate and encourage the Member's adherence to recommended interventions and treatment.
- Ensure timely authorization of services to meet the Member's needs in accordance with the Members Case Management Plan.

A Care Manager will work with the Provider, the member and the member's family in an effort to help Member's gain or regain optimum health or improved functional capability in the right setting. The Care Manager will work with Providers to assess, plan and monitor options and services for members with chronic illness or injury.

I4: Care Transitions

CenCal Health provides Transitional Care Services to Members transferring to one setting, or level of care, to another. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities to home or community-based settings, Community Supports (e.g. Recuperative Care), post-acute care facilities or Long-Term Care settings. The goal of this program is to improve transitions of care for our members by improving quality of care and avoid preventable readmissions.

The Care Transition team will collaborate with the facility staff and/or Member family/caregiver to facilitate the transition of care and ensure member is receiving care at the right setting and receives the necessary services upon discharge.

The Member's assigned Care Manager (e.g., Complex or Enhanced Care Management) will;

- Review the member's current condition and needs
- Assist the facility with preparing and educating the member about the care transition process, coordinating discharge plans, monitoring discharge planning activities, and determining the necessity of:
    - Alternative short and/or long-term living arrangements or placement efforts
    - Home care needs such as home health visits, DMEs, or medical supplies
    - Linkages to alternative financial and community resources available to the member such as adult day care, IHSS, MSSP, Recuperative Care, senior centers, meal delivery, waiver programs, etc.
    - Follow up visits with primary care providers and as appropriate, specialty care providers

- Contact community-based organizations and housing agencies as necessary
- Ensure Members with SUD and mental health needs receive treatment for those conditions upon discharge.
- Follow up with the member post-transition from the SNF, ICF or CLHF stay for a minimum of two months or longer depending on the members need.

I5: Pediatric Whole Child Model

The Pediatric Whole Child Program has dedicated nurses and nonclinical professionals who assist providers with timely processing of necessary specialty referrals and service requests, as well as provide care coordination and care transition services to members. The Pediatric Program is designed as a "one-stop

shop" for providers to obtain covered services for children and youth under the age of 21. The Pediatric team is comprised of a group of specialized staff who perform both utilization review and case management activities. Similar to CenCal Health's Adult Case Management Program, pediatric care coordination and care transition services are dependent on active family and/or caregiver participation.

The Pediatric Team processes, facilitates, and/or coordinates:

- Referrals (RAF)
- Prior authorization requests (50-1, 18-1, 20-1)
- Care coordination of healthcare services or with specialized programs, such as CCS, TCRC, LEA, etc.
- Care transition from one setting to another
- Individualized (or family) guidance, education, community resources

Providers can refer a child or youth under the age of 21 to the Pediatric Whole Child Program case management the same way they would refer an adult to case management or care transitions. Complete a CM Referral Form found at www.cencalhealth.org, under the Provider tab. Authorization requests (50-1, 18-1, 20-1) and referrals (RAF) are also submitted the same way as for adults, via the Provider Portal.

I6: Community Supports

Community Supports are medically appropriate and cost-effective alternative services. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations, and CenCal Health has elected to offer some Community Support services.

Community Supports are optional services for CenCal Health to offer and are optional for members to receive. As of January 1, 2023, CenCal Health offers the following

Community Supports:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Medically Tailored Meals
- Sobering Center
- Recuperative Care

Care Management Services

Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible members. Community Supports will typically be provided by community-based organizations and providers. ECM Providers may also serve as Community Supports Providers, if they have appropriate experience.

Members Eligible to Receive Community Supports

CenCal Health must determine eligibility for a pre-approved Community Supports using the DHCS Community Supports definitions, which contain specific eligibility

criteria for each Community Supports. CenCal Health is also expected to determine that a Community Supports is a medically appropriate and cost-effective alternative to a Medi-Cal Covered Service. When making such determinations, CenCal Health must apply a consistent methodology to all members within a particular county.

Making a Referral for Community Supports
Referrals for Community Supports may be made by a physician, an CenCal Health member or their caregiver, community service agency, hospital or health care provider, or an ECM or Community Supports provider. Community Support Information and Referral Forms are on CenCal Health's website.

Community Supports Authorizations
Authorization through CenCal Health is required for members to obtain Community Supports. CenCal Health staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to determine eligibility. The authorization process entails eligibility screening, the required Information and Referral form associated to that specific Community Supports service,
completion of a Member Care Plan by the ECM Provider (if receiving ECM services), and decision-making by CenCal Health. If approved after CenCal Health's assessment, the member may receive Community Supports. Some Community Supports, such as housing deposits, are limited to once per lifetime.

Utilization management procedures will consider the goals of each Community Supports and CenCal Health will not categorically deny or discontinue a Community Supports irrespective of member outcomes or circumstance. Some Community Supports will require periodic reauthorization by submitting an Authorization Request to the Utilization Management Department, along with any necessary documentation for review. Documentation for the reauthorization may be submitted through the Provider Portal.

I7: Community Health Worker
Community Health Worker (CHW) services became a Medi-Cal benefit on July 1, 2022. CHW services are preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. Importantly, CHW services provide a mechanism for the delivery of equitable and culturally competent care for CenCal Health members which align with CenCal Health's Population Health Management program. CenCal Health covers CHW services for members that meet criteria in accordance with CenCal Health Policy and DHCS requirements.

CenCal Health will use data-driven approaches to determine and understand populations who should be prioritized for CHW services using social determinant of health data, population health management risk stratification data, utilization data,

and input from local providers. Generally, CenCal Health Members are eligible for CHW services if the following criteria are met:

- The presence or risk of one or more chronic conditions or environmental health exposure;
- Exposure to violence or trauma;
- The presence of barriers in meeting health needs; or
- The presence of a need which will benefit from the provision of those preventive care services provided by CHWs.

Additional detail regarding member eligibility for CHW services can be found in DHCS All Plan Letter 22-016: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-016.pdf

Those individuals wishing to provide CHW services must meet certain qualification requirements. Those requirements include:

- Lived experience that aligns with the Member or population being served
- Professional certification **or** work experience of at least 2,000 hours in the past 3 years

Formal CHW certification, if not present, is required within 18 months of becoming a contracted CHW. Additionally, an annual 6 hours of ongoing training is required for all CHWs. All CHWs must be supervised by an organization or provider who holds responsibility for ensuring that CHWs meet all training and ongoing education requirements. It is this supervising provider or organization who will contract with CenCal Health and bill for CHW services, and will submit to CenCal Health a roster of all CHWs providing services to CenCal Health Members. CenCal Health will verify that all applicable requirements are met during the Contracting and Credentialing process.

CHW services require a Treatment Authorization Request (TAR) from a licensed practitioner. Services are recognized in 30-minute units, and the first 12 units (6 hours) are auto-approved through the initial TAR. For requests in excess of the initial 12 units, a written Care Plan is required and must be submitted to CenCal Health. The Care Plan must be:

- Written by one or more individual licensed providers (does not need to be the Supervising Provider);
- Clear regarding the objectives of continued CHW services to address the Member's condition, including the services required; and
- Reviewed every six months.

Required Care Plan components include:

- Specify the condition that the service is being ordered for and be relevant to the condition;
- Other health care professionals providing treatment for the condition or barrier;
- Written objectives that specifically address the recipient's condition or barrier affecting their health;
- The specific services required for meeting the written objectives; and
- The frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

Additional information regarding the provision of CHW services can be found in CenCal Health's Community Health Worker policy, available to providers upon request.

Section J: Disease Management Programs

J1: Disease Management

CenCal Health offers two disease management programs:

- Diabetes Condition Support
- Heart Condition Support

All programs provide a comprehensive, ongoing, and coordinated approach to achieving desired health outcomes.

These outcomes include improving patient's clinical condition and quality of life.

CenCal Health disease management programs help facilitate patient's care, and also offer, support to care providers.

Benefits include:

- Access to patient specific condition monitoring
- Collaboration to support treatment plan
- Assistance in educating patients on self-management (which includes prevention of disease exacerbation and complications)
- Use of evidence-based practice guidelines in program content

CenCal Health members who qualify for disease management program support are enrolled in these programs and may opt out of the program at any time.

Interventions are based on severity level and include, but are not limited to:

- Enhanced health education for all members (welcome packet containing health education and program information)
- Telephonic health coaching from a nurse
- Care coordination support
- Community resource referrals

CenCal Health Disease Management Program Eligibility
Who is eligible?

- CenCal Health Members

  And

- Diagnosis of diabetes mellitus or heart disease

If you want to refer a new patient or confirm a patient is in the program call CenCal Health Disease Management Department (805)364-9330.

J2: Substance Use Disorder Program

The Substance Use Disorder (SUD) Program's concentration is to increase CenCal Health's participation in community-wide efforts in SUD treatment, prevention, and education. Included in this effort is a SUD care management program.

As a member of the Santa Barbara and San Luis Obispo Counties' Opioid Safety Coalitions, CenCal Health collaborates with other leaders to support the health of our community as a whole. Because SUD is not an issue that can be addressed alone, our overarching goal to increase communication and partnership with other community providers, agencies, and community-based organizations in this joint effort to better serve our members.

Collaboration: To inquire more about collaborating with CenCal Health's SUD Program, send an email to the program Administrator, at: SUDProgram@cencalhealth.org

Adult Care Management Program:
The SUD Program is founded on the principal that individuals do not choose to have this condition, however they can choose recovery. Our pursuit is to provide the support to do so because recovery is a journey and it is possible. Our goal is

to empower our members to take back control of their lives and to gain freedom from their Substance Use Disorder.

The SUD care management program is a voluntary program. It will assist with navigating the process of accessing treatment and in addressing medical conditions for whole person care. Once enrolled, a Registered Nurse (RN) will complete assessments with the member to determine their needs and to identify goals. The members will then collaborate with the RN to improve their quality of life and learn how to manage their condition. Most interactions between the RN and the member will be conducted via telehealth.

Services:

- Education:
  To maintain health and recovery, focusing on whole person care, including:
  - Substance use education
  - Focused health education

  - Treatment options for SUD and other identified health conditions
  - Teaching self-management of condition(s) and coordination of care
- Assistance with:
  - Coordination of care between providers
  - Establishing care and follow-up visits to providers
  - Maintain compliance with physician directed treatment plans and prescription medications
- Coordinating referrals to County Behavioral Wellness treatment providers and other community resources
- 24-Hour Nurse Advice Line

Eligibility:

- CenCal Health member age 18 or older
- A primary Substance Use Disorder or medical condition that is caused or affected by Substance Use.
- Willingness to participate in the care plan and care management services

Referrals:

- Provider: Case Management referral through the provider services portal
- Member Self-referral: Direct contact with Case Management at (805)562-1082 or Member Services at (877)814-1861

Section K: Claims and Billing Guidelines

K1: Claims Billing

CenCal Health follows the Medi-Cal guidelines and benefits outlined in the Manuals published by the State of California, with a few exceptions. Please see Benefits and Exclusions information for specific programs found in the Benefits Summary section of this Provider Manual. For specific claim questions, you may contact our Claims Customer Service Representatives. The address and telephone number for the Claims Customer Service Team is listed at the end of this section.

Below is a listing of bullet points outlining the general billing requirements. Bullets apply to all programs, except where specific programs are indicated:

- Claims may be submitted electronically (HIPAA compliant format), through a clearinghouse, via our Website at www.cencalhealth.org, or on a hard copy claim form.

- "Clean" claims will be processed within 45 working days of receipt. Clean claims are claims that include all of the necessary and accurate and valid data for adjudication. This includes, but is not limited to, name, gender, date of birth, subscriber number of member; ICD-10 diagnosis code(s), CPT/HCPCS codes, modifiers, billed charges, applicable authorization number(s), place of

service, quantity of services, bill type and the NPI – National Provider Identification number.

- For Contracted Providers, claims payment is payable at the contracted rate. Payment will not exceed billed charges unless specifically stated in the contract.

- For Non-Contracted Providers, claims payment is payable at the Medi-Cal rate; additionally, payment will not exceed billed charges.

Member administrative fees or surcharges: Under no circumstances whatsoever may a Provider collect or attempt to collect fees from a CenCal Health Member (Medi-Cal beneficiary) for any non-clinical or administrative services, including but not limited to fees for: enrollment or subscription, appointment access, filling out forms or prescriptions, or for late arrival or absence from an appointment (also known as "no-show" fees). Providers must refer any CenCal Health Member who is habitually late to or absent from appointments to CenCal Health's Member Services department. CenCal Health will follow-up with the Member and provide any education or outreach needed. Providers must immediately return any such collected fees to the Member, and may be subject to termination from the network for violating this policy. Any such fees not returned to the Member may be withheld from future claim payments to the Provider.

Ambulatory Surgery Centers and Surgical Implant Billing: For Ambulatory Surgery Center (ASC) facilities in the CenCal Health network that are paid according to Medicare rates, it is acknowledged that Medicare typically bundles in the value of surgical implants to the global facility fee paid to ASC facilities. The ASC fee is thusly inclusive of the cost of those surgical implants.

CenCal Health has identified a list of surgical Implant Procedures (below) involving the use of implanted devices and associated supplies, whose value is included in the Medicare ASC fee schedule rate paid by CenCal Health, including but not limited to:

Implant Procedure	Associated CPT Procedure Codes
Joint Replacement Surgery	27446, 27447
Pacemakers	33206, 33207, 33208, 33212, 33213, 33214, 33221, 33227, 33228, 33229
Defibrillators	33230, 33231, 33240, 33249, 33262, 33263, 33264, 33270, 33271
Cardiac Event Recorders	33282
Infusion Pumps	62360, 62361, 62362

Neurostimulators	61885, 61886, 63650, 63663, 63664, 63665, 63685, 64568, 64575, 64580, 64581, and 64590
Cochlear Implants	69930

Implants and supplies billed by ASC facilities in conjunction with the above Implant Procedures are not eligible for separate reimbursement if the facility is reimbursed at Medicare rates. The Associated CPT Procedure Codes are provided as a reference – any changes to CPT codes associated with the Implant Procedures described above may be incorporated to this policy at any time, at the sole discretion of CenCal Health.

Whole Child Model (WCM) and California Children's Services (CCS)
Effective July 01, 2018, CenCal Health assumed the responsibility of both Santa Barbara and San Luis Obispo counties for the Utilization and Claims payment for CCS eligible members that reside in these counties. Providers must be CCS certified for the specialty services they render.

Standard CenCal Health claim submission, claim correction, dispute/appeal, and timely filing requirements as outlined elsewhere in the Provider Manual and on our website also apply to claims for CCS services rendered to CenCal Health members.

Baby/NICU services may need to be billed using the mother's Member ID for the first two months of life beginning with the month of birth and ensure the correct relationship code is utilized.

Please visit the CenCal Health website for additional Claims and Billing Guidelines or the Medi-Cal Manual.

Denied Claims
Providers are requested to review denial explain code(s), correct the issue(s), and rebill the claim for further consideration of payment. CenCal Health must receive any corrections within 6 months from the date of the Explanation of Payment on which the claim originally appeared. Any corrections received after the end of the sixth month will not be considered.

Claims received after 6 months from initial Explanation of Payment date or month in which services were rendered are subject to payment reduction.

Disputes
If you do not agree with any decision made by CenCal Health with respect to payment or denial, you may dispute the decision. Submit a Dispute Form with all the information, including any attachments/documentation, for consideration of payment within 6 months of the initial EOP date. The appropriate staff member will review your dispute and you will be informed of the decision, in writing, within 45

working days of receipt of the dispute. This applies to all CenCal Health programs.

Appeals
An appeal may be submitted to contest the processing, payment or non-payment of a previously submitted dispute. Providers must submit in writing within 90 days of the action/inaction precipitating the complaint. Failure to submit an appeal within this 90-day period will result in the appeal being denied.

CONTACT INFORMATION FOR CLAIMS:
Submit Original Claims to:
CenCal Health
P.O. Box 948
Goleta, CA 93116-0948

Send Claim Disputes and Appeals:
CenCal Health
Attention: Claims Department
4050 Calle Real
Santa Barbara, CA 93110

Telephone Claim Inquiries:
805-685-9525 ext. 1083
800-421-2560 ext. 1083

Email Inquiries:
CencalClaims@Cencalhealth.org

K2: Payment Procedures for CenCal Health Members

Billing and Payment for Inpatient Services
A day of service is billed and reimbursed for each Member who occupies an inpatient bed at 12:00 midnight in the Hospital facility. Regarding a newborn, the mother's ID number may be used for the baby for the month of birth and through the end of the second month following birth. Once a newborn is assigned his/her own Medi-Cal identification number, that number will be used on all future claims and the mother's ID can no longer be submitted.

Hospital should not separately bill for outpatient, urgent care, and emergency services provided to a Member within twenty-four (24) hours of the admission of the Member to Hospital when the foregoing services are directly related to the condition(s) for which the Member is admitted to Hospital.

Claims Submission Timeliness
Providers shall bill CenCal Health for medical services on the UB-04 or its successor, on the CMS-1500 or its successor, or in an electronic format using industry standards as specified by CenCal Health and/or Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed by the parties. In order to qualify for full payment, Hospitals should submit the claims form to CenCal Health within one

hundred and eighty (180) days from the date of service for professional/outpatient claims. Claims received in the 7th to 9th month from the date of service will be paid at 75% of the allowable, and claims received in the 10th to 12th month from the date of service will be paid at the 50% of the allowable.

Claims that are submitted after one year from the date of service will not be considered without a valid reason for the delay and supportive documentation.

Providers shall comply with existing State and Federal law and regulations pertaining to the issuance of explanations of payment (EOP's) for CenCal Health Members. Additional information on EOP's can be found in the Claims Section of this Provider Manual.

Providers shall be aware that any other health program (including Medicare) must be billed and recoveries made prior to billing State programs. Such rules shall also apply to CenCal Health's administration of the Medi-Cal Program. If CenCal Health receives a claim and determines that another insurance has

been, or should have been billed, CenCal Health shall process such claims, reduce payment, or deny claims as appropriate, with notice of such reduction or denial indicated on the EOP. See proceeding section on Other Health Coverage Section K3 of the Provider Manual.

Claims Processing
CenCal Health will receive and process a clean claim in a timely manner and according to standards set forth in the Hospital Services Agreement, the EDS manual or in this Provider Manual.

Payment Requirements/Responsibilities with the Prudent Layperson Standard for Emergency Services
The determination of whether the prudent layperson standard was met, as defined in the definition of Emergency Services, Article 1, Definitions, of the Agreement, and in the AUTHORIZATIONS section of the Provider Obligations section of this Provider Manual will be made on a case-by-case basis. Except that CenCal Health coverage may be based on diagnosis code and may set reasonable claim payment deadlines.

CenCal Health may not deny coverage solely based on diagnosis code(s), nor deny coverage of this basis and then require submission of the claim as part of an appeal process. Prior to denying coverage or modifying a claim for payment, CenCal Health will determine whether the prudent layperson standard has been met on the basis of all pertinent documentation, with focus on the presenting symptoms (and not on the final diagnosis). Additionally, CenCal Health will take into account that the decision to seek Emergency Services was made by a prudent layperson (rather than a medical professional).

Emergency Room, Urgent Care, and Treatment/Exam Room Claims Processing
Hospital should follow the general guidelines as indicated in the Claims Section of

this Provider Manual when billing these claim types.

Inquiries and Appeals Regarding Claims Processing and/or Payment
If the Hospital has an inquiry or an appeal concerning the processing or payment of its claims by CenCal Health for services provided, CenCal Health has established procedures to accommodate the Hospital's desire to have its inquiry or appeal heard, evaluated, and resolved.

K3: Other Health Coverage (OHC) and SBHI & SLOHI

A person covered under CenCal Health may also have other private/group health insurance. Having private/group health insurance does not affect a member's Medi-Cal eligibility in any way.

However, if you are not a participating provider of a recipient's Other Health Coverage (OHC), you should advise the member to obtain services through his

other insurance or Health Maintenance Organization (HMO) Primary Care Physician (PCP) or refer them to a provider who participates in that plan. For instance, if you are the member's PCP through CenCal Health but not the member's PCP through Blue Cross HMO, you should refer the member to their Blue Cross HMO or obtain a treatment authorization from the HMO. CenCal Health will not reimburse for services not authorized by the HMO. If you are not an authorized provider of the recipient's HMO, please refer the member to their HMO and/or ask the member to contact the CenCal Health Member Services Department to reselect a PCP who participates in both programs.

K4: Billing for Members Who Have Other Coverage

State law mandates Medi-Cal to be payer of last resort, and requires the utilization of other available healthcare coverage prior to the utilization of Medi-Cal. Other coverage is always the primary payer and cannot be waived by the member. We ask that you always bill the member's other coverage first prior to billing CenCal Health. If the other coverage denies payment, a copy of the Explanation of Payment (EOP) or denial letter must be sent with your claim to CenCal Health. A list of services that can be billed directly to CenCal Health can be found in the Medi-Cal manual section under Other Health Coverage (OHC): CPT and HCPCS Codes

Providers are required to notify CenCal Health if they believe a member may be entitled to health coverage through a private/group health insurance plan or policy that is not indicated on the member's eligibility record. Providers should call CenCal Health's Finance Department, Recoveries Unit at (805) 562-1081 to report possible other insurance coverage. Providers are prohibited from billing members' other insurance copayment amounts for Eligible Members with Other Coverage.

Locating Recipient's OHC Information:
The Medi-Cal eligibility verification system returns a message that includes OHC information, when known. The eligibility verification system is accessed through the Automated Eligibility Verification System (AEVS) Medi-Cal website at

www.medical.ca.gov

If the member has other health coverage, claims must be received within 60 days from the date of the EOP from the other health carrier to be considered for full payment. Claims received after 60 days from the EOP date fall back to Medi-Cal Submission and Timelines guidelines.

CenCal Health will reimburse the provider up to the Medi-Cal allowable, less the other health coverage payment amount but will not exceed the member's coinsurance amount. CenCal Health will not pay the balance of a provider's bill when the provider has an agreement with the other health coverage to accept its contracted rate as "payment in full".

If the recipient elects to seek services not covered by CenCal Health, CenCal Health is not liable for the cost of those services.

K5: What You Should Know About Medicare HMOs

The Other Health Coverage code "F" identifies Medi-Cal members who receive benefits from Medicare-contracted Health Maintenance Organizations (HMO) in lieu of the fee-for-service Medicare plan. Members who have both Medi-Cal coverage and Medicare HMO coverage must seek medical treatment through the Medicare HMO first. CenCal Health will not pay for the services if the patient elects to go to a provider who is non-participating with the primary plan for care. However, CenCal Health will reimburse for services which are Medi-Cal covered benefits, but which are not covered by the Medicare HMO plan.

Medi-Cal claims for members with Medicare HMO coverage may not be Medicare/Medi-Cal crossover claims (see below). Therefore, to bill Medi-Cal for services not included in the Medicare HMO plan, submit a Medi-Cal claim accompanied by a Remittance Advice (RA), Medicare Remittance Detail, or denial letter showing that the Medicare HMO was billed first.

K6: Medicare/Medi-Cal Crossover Claims

Claims for members who are eligible for both Medicare and Medi-Cal coverage must be billed to Medicare (either electronically or on paper) prior to billing Medi-Cal, with the exception of Medicare non-covered services. A list of Medicare Non-Covered Services can be found in the Medi-Cal manual section under "medi non cpt" and "medi non hcp." CenCal Health may reimburse providers for the Medicare deductible and coinsurance. A claim for Medicare deductible and coinsurance amounts is called a crossover claim.

Medicare uses a consolidated Coordination of Benefits Contractor (COBC) to automatically cross over to Medi-Cal for claims billed to any Medicare contractor for Medicare/Medi-Cal eligible recipients. Note: Providers do not need to rebill to Medi-Cal for claims that automatically cross over.

The California Welfare and Institutions Code (WIC) limits Medi-Cal payments of the deductible and coinsurance to an amount which, when combined with the Medicare payment, should not exceed the amount paid by Medi-Cal for similar services. The combined Medicare/Medi-Cal payment for all services of a claim may not exceed the amounts allowed by CenCal Health.

Providers who accept a patient who is eligible for both Medicare and Medi-Cal cannot bill the member for the Medicare deductible and coinsurance amounts; these amounts can be billed to CenCal Health. However, the provider should bill the patient for his/her share of cost, if any. Providers are encouraged to wait until they receive the Medicare payment prior to collecting the share of cost to avoid collecting amounts greater than the Medicare deductible and/or coinsurance.

Please note: CenCal Health lifted the Referral Authorization Form (RAF) requirement for crossover services. RAFs are still required for non-Medicare benefits for which Medi-Cal will be the primary payer.

Claims submitted to Medicare electronically will automatically crossover to CenCal Health for processing. These claims should appear on your EOP within 45 working days. If your claim has not appeared on an EOP within this timeframe, you can submit your claims via the portal or electronically through your EDI clearing- house. For further assistance please contact your Claims Service Representative at 805-562-1083.
If you have any questions about what other coverage a member has, what carrier to bill first, Other Health Coverage codes or third-party coverage questions, please contact the Recoveries Unit at (805) 562-1081.

Reference Link:
Medicare Non-Covered Services: CPT Codes
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/medinoncpt.pdf

Medicare Non-Covered Services: HCPCS Codes
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/medinonhcp.pdf

Section L: Quality Management

L1: Quality Improvement System

CenCal Health is firmly committed to the delivery of quality healthcare services to its membership. The purpose of CenCal Health's Quality Improvement System is to define a process to continuously improve the quality of care, quality of service, patient safety, and member experience provided by CenCal Health and/or its contracted provider network. This includes actions to monitor, evaluate, and take effective and timely action to address any needed improvements in the quality of care delivered by CenCal Health providers rendering services in any setting. The QI process is described in detail below:

- Define the scope of quality of care, quality of service, patient safety, and patient experience.
- Establish staff accountability for monitoring and evaluating quality improvement activities.
- Use measurable indicators to systematically monitor aspects of care, service, safety and patient experience, based on current and proven industry-standard methodologies.
- Identify comparable benchmarks and/or thresholds and goals for monitoring of meaningful, industry-standard, performance indicators.
- Sustain quality of care and service when benchmarks and/or goals are achieved, or identify opportunities to improve when measurements fall outside thresholds.
- Evaluate barriers that are directly associated with continued improvement, and assess the potential for CenCal Health to mitigate each barrier and resolve identified problems.
- Based on identified barriers, design relevant, strong and timely interventions and take action to correct identified barriers.
- Systematically evaluate the effectiveness of those actions using relevant and reliable measurements.
- Communicate results to the appropriate committees and stakeholders, including but not limited to CenCal Health's Board of Directors.
- At appropriate intervals re-evaluate performance using comparable measurements; assess performance relative to benchmarks and goals; and identify remaining barriers, if any. Based on findings implement new and/or improved interventions as necessary.

To assure appropriate resource allocation to support the quality function, an organization-wide Quality Program Work Plan and Assessment are developed annually in congruence with CenCal Health's Quality Program and CenCal Health's Strategic Plan.

An annual assessment is undertaken to systematically evaluate progress made toward the work plan of the prior year. The assessment assures CenCal Health identifies areas of success and opportunities for improvement in the coming year. Those identified opportunities are used to plan new activities or refine existing ones in order to prospectively refine the Quality Improvement System. The Work Plan serves as a roadmap of specific quality improvement objectives and it establishes staff accountability for key activities in the coming year.

To assure successful performance of the Quality Improvement System, with the annual development of CenCal Health's Quality Program Work Plan, CenCal Health's leadership sets appropriate goals and objectives for staff.

For additional information, please reference the CenCal Health Quality Program cencalhealth.org/providers/quality-of-care/quality-program/

L2: Quality of Care Review Process

CenCal Health is committed to ensuring our members receive appropriate medical care and services. CenCal Health has a process to identify and investigate potential quality of care issues (PQIs) and initiate corrective action when appropriate. This helps to continually improve the quality of care delivered to our members.

PQI sources include:

- Member originated:
  - Most significant source of complaints. Members can contact our toll-free number *(877) 814-1861* or can submit a complaint in person or in writing.
- External Referral (not member originated)
  - CenCal Health's contracted providers, community agencies, and liaisons (CCS, APS, hospital case managers) may email concerns to PQI@cencalhealth.org.
- Internal Referral
  - Any of CenCal Health's staff may identify PQIs and email them to PQI@cencalhealth.org.

Review Process

The assigned PQI review nurse or designee will determine whether the complaint includes any clinical component, and if so, initiates a review as follows:

- Relevant medical records are obtained including practitioner chart notes, Emergency Department records, pharmacy profile, and a response from the practitioner when appropriate.
- Additional review or a focused site review may be required if the medical records, pharmacy, or claims review are insufficient to answer all clinical concerns.
- CenCal Health's Chief Medical Officer (CMO) or Physician Designee determines if the clinical care met medical standards or was a deviation from standard of care, according to established evidence-based clinical guidelines or community standards. The CMO or Physician Designee will consult with expert clinical specialists if applicable.
- If a deviation from standard of care is suspected, the CMO or Physician Designee will contact the practitioner involved to discuss the concern directly. Formal practitioner interaction may be undertaken to complete the investigation and assure due process as indicated.
- The CMO or Physician Designee may forward quality of care issues to the Peer Review Committee for additional review and determination.
- Opportunities for improvement of care will be shared with the practitioner directly and may include a formal corrective action plan that is appropriately customized to the level of significance of the clinical concern.
- In some instances, ongoing monitoring of practitioners may be required to assure that clinical practices continue to meet standards of care.

- All medical record documentation, investigations, outcomes, or allegations are held strictly confidential by CenCal Health. No portion of the information related to the investigation is shared with anyone not authorized to review the information.

L3: Quality Performance Reporting

Contracted Providers are required to participate in CenCal Health's quality improvement activities. Such activities include but are not limited to those set forth in CenCal Health's Quality Program Description, including:

- Utilization and care management programs
- Managed Care Accountability Set (MCAS) data collection
- Plan-Do-Study-Act (PDSA)
- Other quality improvement and health equity activities, policies, or processes

These activities are in accordance with DHCS All Plan Letter (APL) 19-017 to identify improvements in quality of care for our membership to monitor, evaluate, and address accordingly.

Providers receive information relating to CenCal Health's quality of care through methods including but not limited to summaries and/or announcements in provider bulletins, site visit reports, presentation of results to providers that participate on committees that comprise CenCal Health's quality committee structure, and on CenCal Health's website.

Members receive information through methods including but not limited to summaries and/or announcements in member bulletins and on CenCal Health's website.

Providers and members may also request a hardcopy of CenCal Health's quality performance results by calling the Quality Measurement team at 800-421-2560 extension 1609.

L4: Quality Care Incentive Program

The Quality Care Incentive Program (QCIP) serves to identify members who are due for clinically recommended aspects of care to further assist PCPs in providing comprehensive high quality health care for members. This innovative program encourages increased utilization of evidence-based treatment, screening, and preventive health services.

Performance & Payment Methodology

Performance measurement methodology is equally applied for all capitated PCPs, including but not limited to Federally Qualified Health Centers and Rural Health Centers. Incentive payments are not paid as an additional rate per service or visit. Performance is measured against pre-defined, industry-standard, clinical measures. Measurement results are calculated using NCQA-certified HEDIS® reporting software.

Measures:

Categories and measures are systematically identified for inclusion in the program based on the following criteria:

- Clinical importance for CenCal Health's members
- Areas of needed quality improvement for CenCal Health
- Feasibility of accurate measurement utilizing claim, lab, and registry data
- A balanced distribution of adult and pediatric measures
- A balanced distribution of disease management and preventive care measures
- Alignment with state-wide recommended quality focus areas

Categories and measures are evaluated annually to ensure that the above criteria are met. As priorities change, CenCal Health may update these categories and measures. Categories and measures will be changed no less than annually.

Payment:
Payment performance is calculated, expressed, and reported for each priority measure and all combined priority measures.

- Individual performance is calculated as a percentage, based on the numerator divided by the denominator, for each qualifying measure.
- Overall performance is based on the sum of all measure numerators divided by the sum of all measure denominators for the PCP.
- Performance is expressed using a 5-star performance scale (quintile).
- Star ratings (quintiles) are assigned for each measure, and for all measures in aggregate, by:
    - Ranking PCPs in descending order by their aggregate performance percentage
    - Stratifying the population by quintile, each containing an equal number of PCPs
    - Assigning stars to each quintile -- 5 stars to the highest performing quintile, 4 stars to the next lower quintile, etc.
- If multiple PCPs have the same aggregate clinical score after it is rounded up to 2 decimal places and PCPs are separated into different quintiles, PCPs with equal scores will be included in the higher quintile.
- PCPs earn incentives according to the number of stars earned:
    - Quintile 5 = 5 stars = 100% of total pool
    - Quintile 4 = 4 stars = 80% of total pool
    - Quintile 3 = 3 stars = 60% of total pool
    - Quintile 2 = 2 stars = 40% of total pool
    - Quintile 1 = 1 star = 20% of total pool
- Incentive payments will be completed quarterly reflecting performance through the end of the prior month, with each payment calculation period rolling forward by a quarter.

- PCPs who have less than 30 members in all priority measures combined do not qualify for an incentive payment at the time of quarterly payment calculations. In lieu of an earned QCIP incentive, PCPs that do not qualify receive payment equal to the capitation withhold that they did not have opportunity to earn.

Quality Measures
Identified quality measures encompass aspects of care that PCPs can influence either through direct care or through referral to specialists or other ancillary practitioners. Identified priority measures are consistent with accepted clinical guidelines and are clinically significant to CenCal Health's membership.

Quality of care measures are comprised of six (6) clinical categories of care:

- Behavioral Health
- Women's Health
- Pediatric Care
- Diabetes Care
- Respiratory Care
- Cardiac Care

The quality measures included in each category may be found in the Quality Care Incentive Program Measures. All measure specifications reflect NCQA *HEDIS®* *Volume 2 Technical Specifications* and are updated as measure specifications change. Generally, measures remain within the Quality Care Incentive Program for at least two (2) years to reinforce improvement priorities and expectations, support program stability for PCPs, and increase the potential to achieve overall network performance that meets or exceeds external benchmarks of clinical excellence.

Performance Reporting
Performance reporting occurs monthly for all PCPs and made available via the Provider Portal on CenCal Health's website, www.cencalhealth.org, in the Quality Care Incentive Program module. Reporting is broken up into three (3) sections:

- QCIP Dashboard
- QCIP Performance Overview
- QCIP Financial Overview

For detailed instructions regarding navigation of the Provider Portal screens, please refer to cencalhealth.org/providers/provider-training-resources

Dashboard
The Quality Care Incentive Program Dashboard is a snapshot trended view of both a PCP's overall program performance and their overall financial performance. This page can be filtered by time frame.

Performance Overview

The Quality Care Incentive Program Performance Overview displays quality scoring for each PCP's membership. It includes:

- The PCP's trended performance which can be filtered by:
    - PCP location as applicable
    - CenCal Health identified quality measures for improvement
    - Priority quality measures (incentivized measure have an asterisk*)
    - County of service
    - Time frame
- The PCP's quality performance score by month is reflected on the trend line and performance rates can by displayed by hovering over the trend line marker.
    - Each trend line marker can be clicked on to display that month's performance detail on the QCIP Provider Summary Detail screen. It includes:
        - Number of members in each measure category
        - Number of members in each measure category that received the target services
            - By clicking on the number in this field you can drill into member detail
        - Number of members in each measure category that did not receive the target services
            - By clicking on the number in this field you can drill into member detail
        - Measure category rate
        - Number of members in each measure
        - Number of members in each measure that received targeted services
            - By clicking on the number in this field you can drill into member detail
        - Number of members in each measure that did not receive targeted services
            - By clicking on the number in this field you can drill into member detail
        - Measure rate
        - Number of overall members in the program
        - Number of overall members in the program that received targeted services
            - By clicking on the number in this field you can drill into member detail
        - Number of overall members in the program that did not receive targeted services

- By clicking on the number in this field you can drill into member detail
- Overall program rate

- All member detail includes: member ID number, member name, member date of birth, member age, member gender, member phone number, measure category, and measure name
  - You can click on the member's ID number to view the Member 360 screen.

Financial Overview

The Quality Care Incentive Program Financial Overview displays each PCP's trended incentive payments and the trended incentive funding available to them. It includes:

- Trended financial payments performance which can be filtered by:
  - PCP Location as applicable
  - Time frame
- Financial payment performance by quarter is reflected on the trend line, and payment amounts can by displayed by hovering over the trend line marker. Projected monthly earnings and available funding is also displayed on a separate trend line.
  - Each trend line marker can be clicked on to display the quarterly or the monthly (projected) payment detail on the QCIP Payment Scoring Detail screen.
  - QCIP Payment Scoring Detail includes:
    - Incentive Date
    - Vendor ID
    - Provider NPI
      - By clicking on the number in this field you can drill into the payment detail which includes:
        - Incentive date
        - Vendor ID
        - Provider NPI
        - Total Incentive Payment
        - Member ID
        - Member Name
        - Member Date of Birth
        - Measure Name
        - If the member triggered an incentive payment
    - Provider Name
    - Performance Percentage Rate
    - Quintile in which the provider fell (i.e., Stars Earned)
    - Capitation Withhold Amount

- CenCal Contribution Amount
- Total Financial Pool Available Amount
- Percentage of Financial Pool Available Earned
- Total Incentive Payment Amount

Provider Ranking

The Quality Care Incentive Program Monthly Provider Ranking Report displays the providers star ranking in descending order by their performance score.

- The ranking report can be filtered by:
  - Time frame
- Quality Care Incentive Program Monthly Provider Ranking Report includes:
  - Provider Name
  - Star Ranking
  - Performance score
  - Earning %

Program Support

CenCal Health's Population Health and Provider Services Departments are available to provide orientation regarding quality measures, strategies to maximize data reporting, and sharing of best practices to help maximize service utilization consistent with prevailing evidence-based treatment and preventive health guidelines. Contact QCIP@cencalhealth.org for additional support.
More information can also be found here:

https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

L5: Performance Monitoring

To continually evaluate and improve the quality of care provided to CenCal Health's members, CenCal Health consistently monitors aspects of care prioritized by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS). CenCal Health shares CMS' and DHCS' objective to collect, report, and use a standardized set of measures to drive improvement in Medicaid quality of care.

The Healthcare Effectiveness Data & Information Set (HEDIS[1]) is the primary tool used by CenCal Health to measure the quality of health care provided to our members. Developed by the National Committee for Quality Assurance (NCQA), HEDIS[1] provides a standardized methodology that is used nationally by health plans and regulators to evaluate important aspects of care.

Medi-Cal Managed Care Accountability Set (MCAS)

DHCS annually compiles a list of performance measures called the Medi-Cal Managed Care Accountability Set (MCAS) and requires all Medi-Cal plans to report on these priorities. The MCAS list for Measurement Year (MY) 2022/Reporting Year (RY) 2023 consists of 39 performance measures.

The NCQA 50th percentile is the minimum performance level (MPL) set for 15 of these performance measures. CenCal Health is subject to financial sanctions, quality improvement plans, and/or corrective action for performance that fails to meet or exceed any DHCS MPL.

Below is the complete MCAS list for MY2022/RY2023:

#	MEASURE	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY**	HELD TO MPL
1	Breast Cancer Screening	BCS	Administrative	Yes
2	Cervical Cancer Screening	CCS	Hybrid	Yes
3	Child and Adolescent Well-Care Visits*	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10	Hybrid	Yes
5	Chlamydia Screening in Women	CHL	Administrative	Yes
6	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes
7	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
8	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	HBD	Hybrid	Yes
9	Controlling High Blood Pressure*	CBP	Hybrid	Yes
10	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid	Yes
11	Lead Screening in Children	LSC	Hybrid	Yes
12	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid	Yes
13	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid	Yes
14	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits	W30-6+	Administrative	Yes
15	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits	W30-2+	Administrative	Yes
16	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED	Administrative	No
17	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No
18	Antidepressant Medication	AMM-Cont	Administrative	No

	Management: Continuation Phase Treatment			
19	Asthma Medication Ratio	AMR	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Colorectal Cancer Screening*	COL	Hybrid	No
22	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
23	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No
24	Topical Fluoride for Children	TFL-CH	Administrative	No
25	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No
26	Developmental Screening in the First Three Years of Life	DEV	Administrative	No
27	Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications	SSD	Administrative	No
28	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	No
29	Follow-Up After ED Visit for Substance Use – 7 days*	FUA	Administrative	No
30	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
31	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-Init	Administrative	No
32	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
33	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
34	Pharmacotherapy for Opioid Use Disorder	POD	Administrative	No
35	Plan All-Cause Readmissions	PCR	Administrative	No
36	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No
37	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No
38	Prenatal Immunization Status	PRS-E	ECDS	No
39	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No

***** Measures that will be stratified by race/ethnicity to identify health disparities.

** Methodology Explanation:

- **Administrative:** Measure compliance via Claims, Pharmacy, Immunization Registry, and Supplemental Data
- **Hybrid:** Measure compliance via Administrative, plus medical record review
- **ECDS (Electronic Clinical Data Systems):** Measure compliance via Administrative, plus data from an Electronic Medical Record, Health Information Exchange (HIE)/Clinical Registry, and Case Management System

Medical Record Review and Reporting Process

CenCal Health begins its quality of care reviews every year in January, which includes several steps performed in strict accordance with HEDIS[1] or other CMS quality measurement requirements. These steps include:

- Identification of members who qualify for inclusion in the measures. Members may be included based on their continuity of Medi-Cal eligibility, age, gender, medications, or diagnosis.
- Selection of a statistically significant sample of qualifying members for some measures. Sampling is not an option for many measures.
- Identification of members who have proof of evidence-based, clinically-recommended services, through claims and/or other data sources. These sources may include the California Immunization Registry (CAIR), information supplied by the California Department of Health Care Services (DHCS) and the California Department of Public Health, and clinical results submitted by many of CenCal Health's largest laboratories.
- Any member who does not have proof of services rendered will require medical record review at one or more provider offices, if supplemental medical record data collection is an option. Annually, CenCal Health's medical record reviews are completed from February through May. Every effort is made to accomplish this task in the least intrusive manner possible.
- Reporting of quality of care findings for the Santa Barbara Medi-Cal and San Luis Obispo Medi-Cal programs is submitted in June each year to DHCS and NCQA.

Remote medical record review via secure connection to providers Electronic Medical Record (EMR) systems is CenCal Health's preferred method to collect information from medical record sources. Alternatively, CenCal Health may accept additional data sources that reduce the burden to providers to accommodate medical record review, including EMR data submissions. If you have questions about either of these options to provide medical record documentation, please contact CenCal Health's Quality Measurement Department at (805) 562-1609 or QMGRP@cencalhealth.org.

Because of the excellent health care afforded to our members by CenCal Health's providers, and consistently exceptional quality of care results, CenCal Health has been recognized as a leading managed care organization in California.

L6: Performance Improvement Projects

Performance Improvement Projects (PIPs) are rapid cycle quality improvement projects used to enhance quality and improve healthcare outcomes through process improvements over an 18-month period. The California Department of Healthcare Services (DHCS) requires Medi-Cal Managed Care Plans to participate in a minimum of two (2) PIPs per cycle and must be reported to DHCS' designated External Quality Review Organization (EQRO). PIP Topics are selected in consultation with DHCS and must align with demonstrated areas of poor performance, such as low HEDIS®[1] or CAHPS®[2] scores, and/or DHCS/EQRO recommendations. PIPs must be designed to achieve significant improvement in clinical or non-clinical areas of care expected to have a favorable effect on health outcomes and member satisfaction.

L7: Initial Health Appointments

Primary Care Providers (PCPs) are required to perform an Initial Health Appointment (IHA) for each newly assigned member **within 120 days** of assignment. For members less than 18 months of age, PCPs must ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

IHA's enable PCPs to comprehensively assess and manage a member's current acute, chronic, and preventive health needs, and identify whose health needs require coordination with appropriate community resources and/or other agencies.

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

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

- Comprehensive history of physical and behavioral health status including past and social history as well as a review of organ systems
- Comprehensive physical and behavioral health examination
- Perinatal Services (when applicable)
- Oral health assessment and dental screening and referral for children
- Assessment for age/gender specific preventive screenings or services and health education
- Preventive screening as recommended by the United States Preventive Services Taskforce (USPSTF), Grade A & B recommendations
    - *Not all of the Grade A & B recommendations have to be completed during the IHA, so long as members receive all required screenings in a timely manner consistent with USPSTF guidelines.*
- Identification of risks (e.g., drug, alcohol, or tobacco use)

[1] **HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).**
[2] **CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).**

- Health education and anticipatory guidance appropriate for age
- Diagnosis and plan for treatment of any diseases

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

- Early and Periodic Screening, Diagnostic and Treatment American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule for *members under age 21, including but not limited to provision of all immunizations necessary to ensure that members are up-to-date for their age, Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings.*
- American College of Obstetricians and Gynecologists (ACOG) standards and guidelines for *pregnant or postpartum members*

For pregnant, breastfeeding, or postpartum members, or a parent/guardian of a child under the age of five (5), documentation of a referral to the Women, Infants, and Children Program (WIC) program is mandated by Title 42 CFR 431.635(c).

As soon as possible and no later than 60 calendar days following the IHA or other visit that identified a need for follow-up, PCPs must make arrangements for necessary follow-up, diagnostic, and/or treatment services for risk factors or disease conditions discovered. This includes the provision of immunizations in accordance with the recommendations published by the Advisory Committee on Immunization Practices (ACIP).

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

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

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

Pay for Performance: CenCal Health's new Quality Care Incentive Program encourages IHA visits through measures like Well Child Visits in the First Thirty Months of Life, Child and Adolescent Well-Care Visits, HbA1c Testing, Breast Cancer Screening, and Cervical Cancer Screening. For more information, please go to: https://www.cencalhealth.org/providers/quality-of-care/quality-care-incentive-program/

Monitoring: To assure the completion and documentation of required components addressed during an IHA visit, CenCal Health performs an annual medical record review audit. Findings are shared via IHA Provider Performance Reports and discussed with audited PCPs. The completion of IHA documentation including the use of the SHA is also monitored through the Facility Site Review process.

Member Outreach: CenCal Health performs 3 documented attempts (telephone and mail notification) to informs new members that an IHA is a covered benefit. Members are instructed to call their PCP for an appointment to assure their health care risks and needs are assessed and met timely.

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

Member Population	CPT Billing Codes	ICD-10 Codes
Preventive visit, new patient	99381 - 99387	No restriction
Preventive visit, established patient	99391 - 99397	No restriction
Office visit	CPT and appropriate diagnosis codes: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2	
Prenatal care	Z1032, Z1034, Z1038, Z6500, 59400, 59510, 59610, 59618	Pregnancy related diagnosis

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

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

L8: Mandated Reporting of Provider Preventable Conditions (PPC)

Provider Preventable Conditions (PPCs) consist of health care-acquired conditions (HCAC) when they occur in acute inpatient hospital settings only and other provider-preventable conditions (OPPC) when they occur in any healthcare settings. HCACs are the same as hospital-acquired conditions (HAC) for Medicare, except that Medi-Cal does not require providers to report deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age.

Requirement Timelines

In March 2013, CenCal Health providers were notified that the Department of Health Care Services (DHCS) received approval from the Centers for Medicare & Medicaid Services (CMS) to require providers to report Provider Preventable Conditions (PPCs). Federal legislation prohibits CenCal Health from paying for the treatment of PPCs, and payment adjustment may be applied. PPCs are divided into two categories:

Other Provider Preventable Conditions (OPPCs) in all healthcare settings and health care-acquired conditions (HCACs) in inpatient acute care hospital settings only.

On March 30, 2016, CMS issued new PPC reporting requirements in rulemaking CMS-2390-F, in which CMS further defines OPPC's as conditions that 1) are identified by the State plan; 2) are reasonably preventable through the application of procedures supported by evidence-based guidelines; 3) have a negative consequence for the beneficiary; 4) are auditable, and 5) include, at a minimum, the procedures referenced below.

OPPCs are also known as "never events" and Serious Reportable Events under Medicare. For Medi-Cal, OPPCs are defined as follows: Providers must report the following three OPPCs when these occur in any healthcare setting. "Invasive procedure" refers to a surgical procedure.

- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Providers must report the occurrence of PPCs that are associated with claims for Medi-Cal payment or with courses of treatment prescribed to a CenCal Health beneficiary for which payment would otherwise be available. Providers do not need to report PPCs that existed prior to the initiation of treatment of the beneficiary by the provider. Reporting is required to evaluate whether the occurrence extended care and determine whether CenCal Health can adjust any payment previously made. PPC reporting is mandated for Medi-Cal beneficiaries eligible through the State Medi-Cal Program under Fee-For-Service, as well as for members of CenCal Health.

Inpatient acute care hospitals and facilities are required to report OPPCs and HCACs for any CenCal Health member. To report a PPC, providers must:

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

Providers must submit the form within five (5) days of discovering the event.

Please note: reporting PPC to CenCal Health, or DHCS, for any Medi-Cal beneficiary does not preclude the provider from reporting adverse events and healthcare associated infections (HAIs) to the California Department of Public Health for the same member.

Claims submitted for treatment of PPCs should also be identified on the claim form. For OPPCs, a modifier is required to be reported whereas HCACs must utilize

diagnosis codes, and in some cases procedure codes, to indicate any Corresponding Complication (CC) or Major Complication or Co-morbidity (MCC) related to the PPC.

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

Provider Preventable Conditions

Other Provider Preventable Conditions (OPPC) – reportable in all healthcare settings; claims for OPPC must include the PPC modifiers as indicated in parentheses ().

Health Care-Acquired Conditions (HCAC) – reportable in inpatient acute care hospital settings only; claims for HCACs must include the Corresponding Complication (CC) or Co-Morbidity/Major Complication (MCC) ICD-10 diagnosis codes and/or procedure code; please refer to the list of HCAC claim coding on our website in the Hospital Provider Obligations section of the Provider Manual under Section D, D3.

Providers need to report HCACs only when they occur in inpatient acute care hospitals.

HCACs:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Deep vein thrombosis/pulmonary embolism (excluding pregnant women and children under 21 years of age)
    - Total Knee Replacement
    - Hip Replacement
- Falls/trauma that result in the following:
    - Fracture
    - Dislocation
    - Intracranial injury
    - Crushing injury
    - Burn
      Other injuries
- Foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
    - Diabetic ketoacidosis
    - Nonketotic hyperosmolar coma
    - Hypoglycemic coma
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity

- Stage III or IV pressure ulcers
- Surgical site infection
    - Mediastinitis following coronary artery bypass graft (CABG)
    - Surgical site infections following:
        - Bariatric surgery
            - Laparoscopic gastric bypass
            - Gastroenterostomy
            - Laparoscopic gastric restrictive surgery
        - Orthopedic procedures for spine, neck, shoulder, and elbow
    - Cardiac implantable electronic device (CIED) procedures
- Vascular catheter-associated infection

Claim Reporting

HCAC must utilize diagnosis codes to indicate any Corresponding Complication (CC) or co-morbidity or major complication (MCC) related to the PPC. Federal legislation prohibits Medi- Cal payment for the treatment of PPC, and payment adjustment may be applied.

Please reference the CMS.gov website for a list of required diagnosis codes, and in some cases procedure codes that can be reported on a claim related to HCAC.

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

DHCS's Provider-Preventable Conditions
https://www.dhcs.ca.gov/individuals/Pages/PPC_Reporting.aspx

L9: Adverse Childhood Experiences Screening

An Adverse Childhood Experiences (ACEs) screening evaluates children and adults for trauma that occurred during the first 18 years of life.

Training and Certification

The California Department of Health Care Services (DHCS), in partnership with the California Office of the Surgeon General, created a first-in-the-nation statewide effort to screen patients for ACEs that lead to trauma and the increased likelihood of ACEs-Associated-Health Conditions due to toxic stress.

Detecting ACEs early and connecting patients to interventions, resources, and other supports can improve the health and well-being of individuals and families. By screening, providers can better determine the likelihood a patient is at increased health risk due to a toxic stress response, which can inform patient treatment and encourage the use of trauma-informed care.

The two-hour online curriculum will provide Continuing Medical Education (CME) and Maintenance of Certification (MOC) credits. To sign up, go to:
https://www.acesaware.org/

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

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

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

Coding of the screening is dependent on the resulting score.

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

Screening Tools
The ACEs questionnaire for adults (ages 18 years and older) and Pediatric ACEs and Related Life-events Screener (PEARLS) tools for children (ages 0 to 19 years) are both forms of ACEs screening. Both tools are acceptable for Members aged 18 or 19 years. The ACEs screening portion (Part 1) of the PEARLS tool is also valid for use to conduct ACEs screenings among adults ages 20 years and older. If an alternative version of the ACEs questionnaire for adults is used, it must contain questions on the 10 original categories of ACEs to qualify.

10 original ACE categories:

- Abuse
    1. Physical
    2. Emotional
    3. Sexual
- Neglect
    4. Physical
    5. Emotional
- Household Dysfunction
    6. Parental incarceration
    7. Mental illness
    8. Substance dependence

9. Separation or divorce
10. Intimate partner violence

The ACEs questionnaire and the PEARLS tool are available at the following link: https://www.acesaware.org/screen/screening-for-adverse-childhood-experiences/

Documentation Requirements
Medical record documentation of the ACEs screening must remain in the patient's medical record and be available upon request. It must include:

- Use of appropriate screening tool
- Review of completed screening
- Results
- Interpretation of results
- Discussion with the patient and/or family
- Any appropriate actions taken

L10: Social Determinants of Health (SDOH)

Social Determinants of Health (SDOH) are conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Consistent and reliable collection of SDOH data is vital to identify ways to support our members. There are several health-related social factors that can be improved through the analysis of the member characteristics, health, social, and risk needs. Our providers are the key to identify the health disparities, and their root causes, that are negatively impacting our members' health.

Coding for SDOH

All network providers should include SDOH codes in their billing so that CenCal Health can better identify members needs and find solutions to help them thrive and achieve optimal health. The categories include:

- **Z55** – Problems related to education and literacy
- **Z56** – Problems related to employment and unemployment
- **Z57** – Occupational exposure to risk factors
- **Z58/Z59** – Problems related to housing and economic circumstances
- **Z60** – Problems related to social environment
- **Z62** – Problems related to upbringing
- **Z63** – Other problems related to primary support group, including family circumstances
- **Z64** – Problems related to certain psychosocial circumstances
- **Z65** – Problems related to other psychosocial circumstances

Code	Problems related to education and literacy (8)

Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable and unattainable
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.5	Less than a high school diploma
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified

Code	Problems related to employment and unemployment (*11*)
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment

Code	Occupational exposure to risk factors (11)
Z57.0	Occupational exposure to noise
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor

Code	Problems related to housing and economic circumstances (17)
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.2	Discord with neighbors, lodgers, and landlord
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified

Code	Problems related to social environment (7)
Z60.0	Problems of adjustment to life transitions (life phase, retirement)
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty (migration, social transplantation)
Z60.4	Social exclusion and rejection (physical appearance, illness, behavior)
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problem related to social environment, unspecified

Code	Problems related to upbringing (19)
Z62.0	Inadequate parental supervision and control
Z62.1	Parental overprotection
Z62.21	Child in welfare custody (non-parental family member, foster care)
Z62.22	Institutional upbringing (orphanage or group home)
Z62.29	Other upbringing away from parents
Z62.3	Hostility towards and scapegoating of child

Z62.6	Inappropriate (excessive) parental pressure
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.812	Personal history of neglect in childhood
Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z62.819	Personal history of unspecified abuse in childhood
Z62.820	Parent-biological child conflict
Z62.821	Parent-adopted child conflict
Z62.822	Parent-foster child conflict
Z62.890	Parent-child estrangement NEC
Z62.891	Sibling rivalry
Z62.898	Other specified problems related to upbringing
Z62.9	Problem related to upbringing, unspecified

Code	Other problems related to primary support group, including family circumstances (*12*)
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.31	Absence of family member due to military deployment
Z63.32	Other absence of family member
Z63.4	Disappearance/death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.71	Stress on family due to return of family from military deployment
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful events affecting family/household (ill/disturbed member)
Z63.8	Other specified problems related to primary support group (discord or estrangement, inadequate support)
Z63.9	Problem related to primary support group, unspecified

Code	Problems related to psychosocial circumstances (3)
Z64.0	Problems related to unwanted pregnancy
Z64.1	Problems related to multiparity
Z64.4	Discord with counselors

Code	Problems related to other psychosocial circumstances (8)
Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.3	Problems related to other legal circumstances (arrest, custody, litigation)
Z65.4	Victim of crime and terrorism
Z65.5	Exposure to disaster, war, and other hostilities
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
Z65.9	Problem related to unspecified psychosocial circumstances

The list is subject to revisions and additions to improve alignment with SDOH data elements.

Reference Link:
https://www.cencalhealth.org/providers/social-determinants-of-health/

Section M: Member Services

M1: Member Rights and Responsibilities

CenCal Health members have certain rights and responsibilities. The Member Handbook will explain those rights and responsibilities. Please visit the CenCal Health website to download the Member Handbook.

Reference Link:
Member Handbook
https://www.cencalhealth.org/members/member-handbook/

M2: Nondiscrimination Notice

Discrimination is against the law. CenCal Health follows State and Federal civil rights laws. CenCal Health does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group, identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. To learn more about Notice of Non-Discrimination, please visit the CenCal Health website and download the Member Handbook.

Reference Link:
CenCal Health Member Handbook
https://www.cencalhealth.org/members/member-handbook/

M3: Mid-Month Process

Mid-Month changes are made to facilitate continuity of care and prevent access problems. Requests for Mid-Months can be made by either the member or the provider. If a provider calls CenCal Health to request a Mid-Month, we will need to speak with the member before the request can be approved.

The following are the guidelines regarding Mid-Months:

- The cut-off date (last date) to request a Mid-Month will vary from month to month, but it's usually around the 13th or 14th of the month. After this date, we will no longer be able to change a member's PCP retro-actively to the 1st of the current month.

- **All Mid-Month changes are retroactive to the first of the current month** regardless of the day in which the Mid-Month was processed and/or approved. By approving a Mid-Month, the provider agrees to case manage a member for all medical care received retroactively to the first day of the month.

- CenCal Health's eligibility system and website eligibility system will be updated immediately to reflect Mid-Month changes. Providers are urged to make notations to their capitation monthly report indicating a Mid-month addition to their list as well as a Mid-Month deletion. **Please remember that a provider can treat a member immediately, after the Mid-Month has been approved.**

- A Mid-Month Capitation Report is generated after the cut-off date and mailed out to the provider. It will list all members that were retroactively added back to the first of the current month.

The Member Services staff uses the following Mid-Month criteria:

- The member has an established relationship with the PCP they are requesting
- The member has an appointment in the current month
- The member needs ongoing or urgent care.
- The Member needs a Child Health and Disability Prevention Program "CHDP" exam and/or immunizations
- The member has not been seen in the current month by the PCP that they are currently assigned to

If for whatever reason a Mid-Month does not process correctly, CenCal Health has an administrative referral process by which a provider's claim can be processed. Therefore, if the provider approves the Mid-Month and determines that the member does not appear on their capitation report, the provider can request an administrative referral from CenCal Health which will ensure that the provider's claim is processed and will not require a referral from the original PCP.

M4: Assistance with Member No-Shows

CenCal Health recognizes that members missing their appointments can create scheduling issues for providers. CenCal Health's Member Services Department offers

support and assistance with member "no-shows" through member coaching and education, important tools when helping members understand the importance of keeping scheduled appointments and the consequences should they miss them.

Providers can request the following assistance by contacting the Member Services Department:

- Member Services contacts the member and provides "***direct one on one***" education regarding missed appointments. This should occur as soon as the provider identifies that the member has missed an appointment without cancelling, thereby addressing the issue before it becomes a problem.
- If transportation has been identified as a barrier to keeping appointments, Member Services can provide members with information regarding alternate transportation and offer referrals to community resources.
- Member Services will strive to identify and address any other issues that may be leading to the member missing appointments.

Articles regarding the importance of keeping scheduled appointments regularly appear in the CenCal Health Member Newsletter.

Providers can call the Member Services Department for assistance, Monday through Friday, 8AM to 5PM at (877) 814-1861 or fax a list of members to (805) 692-1684. Providers will be notified, once education has been provided.

Section N: Language Assistance Program

N1: Obtaining Access to Cultural and Linguistic Services

State and Federal regulations require CenCal Health to make interpreter and translation services available for limited English proficient members. Limited English proficient (LEP) members include those who have a limited ability to read, speak, write or understand English. CenCal Health is also required to facilitate, promote and provide training in cultural competency for its staff, as well as for health network staff and CenCal Health providers. CenCal Health's Cultural and Linguistic Services program provides and facilitates interpreter and translation services.

The Department of Health Care Services (DHCS) periodically audits CenCal Health's Language Assistance Program which includes interpreter and translation services, as well as on our provider trainings. DHCS auditors may select individual provider offices to review as a part of this audit, to verify whether LEP members are informed of the availability of language assistance and have been offered

interpreter services. CenCal Health will contact, in advance, provider offices selected by the DHCS to participate in its cultural and linguistic services audit when possible.

N2: Accessing Interpreter Services

Providers may request interpreter services for their CenCal Health patients with limited English proficiency. We encourage providers to use CenCal Health's 24/7 telephonic interpreter Service for most routine appointments. Video Remote Interpreting (VRI) for face-to-face interpreter needs for ASL, Spanish and 20 other languages are also now available for specialty appointments through Certified Language International by using their assigned password. Providers may also request face-to-face interpreter services (Spanish) if criteria for these services are met for a network interpreter to be sent to the appointment. For help in identifying your patient's preferred language, see the Provider section of the CenCal Health website.

How to Request Interpreter Services

- Verify the member's eligibility and identify if the member is enrolled with CenCal Health. The member MUST be a member of CenCal Health to use CenCal Health interpreting services, and you may be responsible for payment if determined to be misusing services for non-CenCal Health members.
    - Telephonic interpreter service is to be used for all routine services that do not meet the criteria as noted in Section N, N7 Language Access Program. This service is available 24 hours a day, seven days a week.
    - Video Remote Interpreting (VRI) service is to be used for ASL members and 21 other languages available on demand. Please note that only ASL and Spanish is available 24/7. For cost-effectiveness, CenCal Health asks providers to utilize CLI's voice-only interpreting services whenever possible, and use VRI for complex appointments. For a list of all languages go to cencalhealth.org/providers/cultural-linguistic-resources/
    - Face-to-face (in-person) Spanish and ASL interpreter services, are available based upon the noted criteria in Section N7. This service is available for scheduled medical appointments in an ambulatory setting, and requires at least five working days' advance notice.
    - American Sign Language is available on-demand through VRI, however, if it requires a face-to-face interpreter in-person, please request at least 5 working days in advance notice.

- Please have the following information ready for Face-to-Face scheduling at the time of the request:
    - Member's name
    - Member's CIN or ID#
    - Member's gender and age
    - Date and Time of appointment
    - Type of visit and approximate duration within the noted criteria (does not apply to ASL)
    - Name of doctor/facility
    - Address and phone number of appointment/location

- If the member is eligible with CenCal Health, please contact CenCal Health's Member Services Department by calling **(877) 814-1861**. Prior authorization is required if criteria is met.

Reference Link:
Language List and Hours of operation
https://www.cencalhealth.org/providers/cultural-linguistic-resources/

N3: Documenting Member Refusal of Interpreter Services

CenCal Health ensures that qualified interpreters are professionally trained, culturally competent and well-versed in medical terminology and managed care concepts. Because of these requirements, it is important that provider offices document when members refuse to use the telephonic or face-to-face qualified interpreter services. We recommend documenting the refusal of any of the interpreter services available to providers (telephonic, VRI, or face-to-face) in the member's record. Documenting refusals can protect the provider and the provider's practice and it ensures consistency when medical records are monitored through site reviews or audits to ensure adequacy of CenCal Health's Language Assistance program.

N4: Tips for Documenting Telephonic, Video or Face-to-Face Interpreter Services

- CenCal Health recommends documenting whenever telephonic, VRI or face-to-face, including ASL interpreter services are used, in the member's medical record.
- If the member was offered interpreter services and they refused, it is important to note that refusal in the member record for that visit.
- Using a family member or friend to interpret should be discouraged. However, if the member insists on using a family member or friend, it is extremely important to document this in the medical record. Minors should never be used to interpret. Consider offering a telephonic or video interpreter in addition to the family member/friend to ensure accuracy of interpretation when this occurs.
- For all limited English proficient members, it is a best practice to document the member's preferred language in paper and or electronic medical records in the manner that best fits your practice.

Source: Industry Collaboration Effort (ICE) Tips for Communicating Across Language Barriers; www.iceforhealth.org/.

N5: Working with Interpreters for Face-to-Face, Telephonic, and Video Services

Certified Languages International (https://certifiedlanguages.com) hires the very best interpreters available from a nationwide database.

Our face-to-face interpreters for Spanish and ASL needs are independent contractors who we have assessed and tested to assure that they have the highest level of accuracy and professionalism.

However, language interpretation is a three-way conversation between yourself, your patient and the interpreter. Please discuss concerns or issues together to improve all parties' experience, and report any feedback you would like CenCal

Health to know to CenCal Health's Cultural & Language Program & Resource Coordinator.

N6: Working with Limited English Proficient (LEP) Members

It is important that providers know how to identify, offer and access interpreter services for LEP members. Below are some recommended tips on how to work with limited English proficient members.

- **Who are considered LEP members?** Individuals who do not identify English as their preferred language and who have a limited ability to read, speak, write or understand English, may be considered LEP.

- **How to identify LEP members over the phone**. An LEP member may exhibit the following characteristics:
    - Is quiet or does not respond to questions.
    - Responds with a simple "yes" or "no," or gives inappropriate or inconsistent answers to your questions.
    - May have trouble communicating in English or you may have a very difficult time understanding what he or she is trying to communicate.
    - Identifies as LEP by requesting language assistance.

- **How to offer interpreter services to an LEP member when a member does not speak English and you are unable to discern the language.** If you are unable to identify the language spoken by the LEP member, you should request telephonic or video interpreter services through Certified Languages International (CLI) to identify the language needed.

- **How to best communicate with an LEP member who speaks some English but with whom you are having difficulty communicating**. Speak slowly and clearly with the member. Do not speak loudly or shout. Use simple words and short sentences.

- **How to offer interpreter services to the member**. Here are a couple of recommended ways to offer interpreter services:
    - "I think I am having trouble explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you prefer to speak?"
    - "I am going to connect us with an interpreter. Which language do you speak?" Call Certified Languages International for assistance.
    - If using Video Remote Interpreting (VRI), the member can point to the language they speak.

- Best practice to capture language preference. For LEP members, it is a best practice to capture the member's preferred language and record it in the plan or provider's member data system. You may want to consider asking the following question:

"In order for (provider's name) to be able to communicate most effectively with you, may I ask what is your preferred spoken and written language?

N7: Language Access Program

CenCal Health offers language line assistance and interpreter services for qualifying visits, to assist with communication during medical services for our membership only.

Telephonic and video interpreting services are simple, available 24 hours a day, and free of cost to providers and members. These services can assist with communication between providers and members who do not speak the same language also known as Limited English Proficient (LEP).

To access language services, complete the steps below:

☎ **Telephonic Interpreter Services**

1. Dial the toll-free number: **(800) 225-5254**
2. Provide operator customer code: **48CEN**
3. Indicate to operator that you are calling from **CenCal Health – Providers**
4. Request Language needed
5. Provide your name and phone number, provider's last name, NPI #, CenCal Health member ID and patient name

Video Remote Interpreting (VRI)

1. Go to the VRI web address: **cencalhp.cli-video.com**
2. Enter the VRI access code: **48cencalhp**
3. Enter required information:
    - Caller's full name
    - Phone number
    - Doctor's last name
    - NPI #
    - Member ID #
    - Patients last name
4. Select the appropriate language to connect to an interpreter via video

VRI User Guide for VRI

Face-to-Face Interpreters

Face-To-Face interpreter services may be authorized by CenCal Health for members requiring the following CenCal Health-covered services:

- Services for members who are deaf and hard of hearing (American Sign Language (ASL)
- Abuse or sexual assault issues
- End of life issues/ Hospice
- Complex procedures or courses of therapy
- First Physical Therapy appointment and re-check appointment
- First Oncology Appointment
- First Orthopedic Appointments

Prior authorization via the Member Services Line at (877) 814-1861 is required for face-to-face interpreter services requests for those Spanish-speaking members who meet the criteria noted above. CenCal Health encourages providers to coordinate face-

to-face interpreter services at least 5 business days prior to appointment. Upon authorization of service, the Cultural and Language Program & Resource Coordinator will schedule a qualified interpreter for the requested date of service. For more information regarding Language Assistance, please visit CenCal Health's website.

Reference Link:
User Guider for VRI
https://www.cencalhealth.org/~/media/files/pdfs/providers/for-providers/cultural-and-linguistic/clivriuserguidewithbluestreatmtechsupport202003.pdf?la=en

VRI Frequently Asked Questing
https://www.cencalhealth.org/~/media/files/pdfs/providers/for-providers/cultural-and-linguistic/clivrifaq202003.pdf?la=en

VRI Minimum Requirements
https://www.cencalhealth.org/~/media/files/pdfs/providers/for-providers/cultural-and-linguistic/clivriminimumrequirements202003.pdf?la=en

N8: Language Assistance

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call CenCal Health Member Services at 1-877-814-1861, or if you cannot hear or speak well (TTY/TDD: 1-833-556-2560 or CA Relay at 711).

Reference Link:
CenCal Health Language Assistance Taglines
https://www.cencalhealth.org/~/media/files/pdfs/members/mu-0004142-eng3-0321-m-ms-hiyl-0621-es.pdf

Section O: Provider Complaints and Grievances

O1: Provider Complaints and Grievances

CenCal Health has developed a process to address provider complaints and grievances efficiently and fairly. This policy provides an avenue for contracted and non-contracted providers to bring concerns or opportunities for improvement to CenCal Health's attention, and thus drive CenCal Health's operations and direction, as appropriate.

Definitions

Complaint: A complaint is a request for assistance, or an expression of dissatisfaction related to non-clinical member issues, aspects of CenCal Health's administration of its programs, or other issues.

Grievance: A formal written expression of dissatisfaction by a provider with any aspect of CenCal Health's operations, with the exception of CenCal Health decisions regarding claims or service authorizations, regardless of whether any remedial action is requested or can be taken.

Procedure

1. **Receipt of Provider Claims Inquiries, Disputes or Appeals; and Authorization Inquiries or Appeals**
   If a provider contacts Provider Services with issues outside their purview (claims inquires or appeals, authorization inquiries or appeals, clinical or quality of care concerns), the Provider Services Representative (PSR) will "warm transfer" the caller to the appropriate department. The appropriate department, to address the grievance, unless otherwise requested, shall review and respond as appropriate.

   A. *Receipt and Resolution of a Provider Complaint or Grievance:*
      I. The Provider Services Department is charged with the resolution of provider complaints and grievances. The complaint may be related to non-clinical member issues, aspects of CenCal Health's administration of its programs, or other issues. The provider may file a complaint with the Provider Services

Department via a telephone call, fax, e-mail, or handwritten letter.

II. If a complaint has no clinical or quality of care aspect, the PSR determines whether the provider needs routine assistance or would like to file a formal grievance. Formal grievances must be submitted in writing, preferably on the provider's letterhead.

III. Informal complaints and requests for routine assistance are addressed by the PSR, with assistance from other staff as needed. Formal written acknowledgements or resolutions are generally not necessary for these matters

IV. 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 (5) business days.

V. 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 are resolved within 45 business days.

2. Disclosure to Providers and Members

Providers are informed of their right to file complaints and grievances, and the availability of assistance in the filing process, in a variety of ways. This may include, but is not limited to, through their provider contract agreements or amendments, CenCal Health's website, Provider Bulletins, and in provider materials and manuals issued by CenCal Health and updated periodically.

CenCal Health's grievance system is in addition to any other dispute resolution procedures available to the provider. The provider's failure to use these procedures does not preclude the provider's use of any other remedy provided by law.

CenCal Health's Chief Operating Officer and Legal Counsel will be notified immediately when a provider's legal representative contacts CenCal Health regarding the pursuit of legal action to resolve a complaint or appeal.

CenCal Health will not discriminate or retaliate in any manner, including but not limited to the cancellation of the provider's contract, against a provider who files a grievance.

Grievances shall be received, handled, and resolved without charge to the provider. However, CenCal Health shall have no obligation to reimburse a provider for any costs incurred in connection with filing a complaint or grievance.

3. **Confidentiality and Privacy Regarding Record Retention**
   All provider complaints and appeals shall be placed in designated files and maintained by the Provider Services Quality Liaison for at least ten (10) years after the resolution; the files of the previous two (2) years shall be in an easily accessible place at CenCal Health's offices.

4. **Monitoring of the Process**
   Reports: The Provider Services Quality Liaison will prepare a quarterly summary of provider complaints and grievances to be presented to CenCal Health's Network Management Committee and Board of Directors. The report shall summarize the number and type of provider complaints, grievances, and appeals.

O2: Member Grievance and Appeal Process

Providers or Authorized Representative can offer to help members file a grievance or an appeal. They can also file appeals on their behalf with their patient's consent. The following information explains the process for member grievance and appeal filing.

CenCal Health members have the right to file a grievance about their experiences with the Plan or its providers. While many providers have internal policies for resolving patient complaints/grievances, CenCal Health provides a Grievance and Appeal System for our members to express their dissatisfaction or to appeal a decision that they do not agree with. We do not delegate this activity to our provider network.

For appeals, members have 60 calendar days from the date of the Notice of Action Letter (NOA) or decision to submit an appeal. For Grievances, there is no longer a time limit to file. An appeal or grievance request can be made by the member, the authorized representative or by a provider on behalf of the member, with their consent.

Discrimination Grievances – These types of grievances are processed by a Discrimination Grievance Coordinator to ensure the health plan is in compliance with federal and State nondiscrimination requirements and investigating cases related to any action that would be prohibit by, or out of compliance with, federal and State.

If a member asks to file a grievance or an appeal with the provider, the provider's office staff should give him/her the appropriate forms and instructions. Forms are available in English and Spanish, and copies of these forms should be made readily available for CenCal Health members in your office, and are available at the following links:

Appeal Form: English or Spanish
Grievance Form: English or Spanish

HOW TO ASSIST MEMBERS IN FILING GRIEVANCES OR APPEALS

A grievance or an appeal can be filed by members or on behalf of members by any of the following methods:

☎ By calling CenCal Health's Member Service Department at our toll free number 1- 877 -814-1861.

In person, by visiting CenCal Health.

By completing a Grievance/Appeal Form and/or submitting in writing to:
CenCal Health
Attn: Grievance & Appeals
4050 Calle Real
Santa Barbara, CA 93110

Via website at this link: https://www.cencalhealth.org/members/file-complaint/

Standard and Expedited Review Processed

Standard - In most circumstances, grievance or appeal requests will be processed through the Standard Grievance/Appeal Review Process. This is a 30-day max timeframe for review. The timeframe may however be extended an additional 14 calendar days (for appeals only), if there is a need for additional information to make a decision and/or if the delayed decision is in the best interest to the member.

The standard process include a written resolution of the grievance or appeal within 30 calendar days of filing.

Expedited - An expedited review of a grievance or appeal can be requested in certain cases. This is a 72-hour allowed timeframe from the day it is received and consented from member, for review. This process supports resolution of the appeal within 72 hours when a delay in a decision using the 30-day standard process may seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum function. A CenCal Health physician reviewer will determine if the appeal request meets expedited criteria for processing.

If the expedited process is granted, a physician reviewer who was not involved in the original decision will complete the review and resolution of that appeal is provided verbally to the requestor within the 72 hours of filing. Written notification is also provided within 72-hours in most cases, only delayed for translation needs.

If the CenCal Health Physician Reviewer determines the appeal does not meet expedited criteria for processing, the process will revert to the standard appeal process for resolution. Attempts will be made to verbally notify the member or authorized representative of this change to a standard 30-day process, and the verbal notification is also followed by a written Acknowledgement Letter initiating the standard grievance or appeal.

PROVIDER RESPONSIBILITIES

Providers must cooperate with CenCal Health in identifying, processing and resolving all member grievances and appeals.

Cooperation in this process includes, but is not limited to:

- Speaking with CenCal Health Grievance & Appeals Coordinators to assist with resolving the grievance or appeal in a reasonable manner.
- Having designated staff available for grievance and appeal investigation.
- Completing a provider response in writing, if requested. Providers may choose to respond in writing at any time as well and often provide written documentation of their requests when filing on a member's behalf.
- Responding to all information/documentation requests made by CenCal Health related to the grievance or appeal: medical record requests, provider's response to the complaint, scheduling documentation/ phone logs and/or other supporting documentation needed for CenCal Health's review.
- Responding to requests timely (within 7 business days at a maximum).

If providers would like to file a grievance or appeal on behalf of a member, providers must obtain written consent from members to do so. This signed consent should be submitted with your appeal request. CenCal Health is able to initiate a grievance or appeal filed by a provider for a member, with at the least, verbal authorization from the member. DHCS requires CenCal Health to request written consent even if verbal authorization is obtained, so it is best to obtain written authorization for submission when filing the grievance or appeal request.

CenCal Health's Grievance & Appeal Team is available to answer any questions you may have about this process at any time. Please contact us through the Member Services Call Center at 1-877-814-1861 and ask to speak with a Grievance Coordinator.

Section P: Health Education and Information

P1: Health Education Services

CenCal Health members are eligible to receive health education services at no charge as part of preventive and primary healthcare visits. Health risk behaviors,

health practices, and health education needs related to health conditions should be identified, and educational interventions, including counseling and referral for health education services, should be conducted and documented in the member's Medical Record.

A variety of educational strategies, methods, and materials should be used that are appropriate for the CenCal Health member population and that are effective in achieving behavioral change for improved health.

Resources and Support for Providers

CenCal Health can assist you with developing and delivering culturally and linguistically appropriate health education interventions for your patients.

Training is available for the following areas:

- Techniques to enhance effectiveness of provider/patient interaction

- Health plan and community health education resources available and procedures for referring individual Members to appropriate services
- Health education requirement standards, guidelines and monitoring
- Population Needs Assessment findings
- Other provider health education needs

For information to support health education services in your practice, contact the Health Promotion team at healthed@cencalhealth.org or (800) 421-2560 ext. 3126.

Resources for CenCal Health Members

CenCal Health members can also be referred to the Health Education Request Line at (800) 421-2560 ext. 3126 to request specific materials or other health education needs from CenCal Health.

CenCal Health's library of patient education materials are available for download at no cost, in English and Spanish.

Reference Link:
https://www.cencalhealth.org/health-and-wellness/

Section Q: Fraud Waste and Abuse (FWA) & Protected Health Information (PHI)

Q1 Overview of Fraud, Waste and Abuse

CenCal Health is dedicated to the detection, investigation, prevention, and reporting of suspected or actual fraud, waste, and abuse (FWA). CenCal Health's Fraud Program is designed to prevent and detect suspected and or actual FWA. The Special Investigations Unit (SIU) in the Compliance Department investigates all reports of suspected FWA. The SIU works in tandem with state and federal agencies, and law enforcement to report individuals or organizations who may be involved in FWA activities. Under the terms of the contract between CenCal Health and its provider network, providers must report suspected cases of FWA to CenCal Health. CenCal Health maintains and supports reporting of any suspected FWA through variety of reporting channels including an anonymous reporting hotline. This section of the Provider Manual provides a general guidance for providers and other partners in identifying and reporting FWA to CenCal Health.

In addition, CenCal Health's website includes sections dedicated specifically to FWA concerning Members and Providers. The website highlights many of the same elements included in this manual and includes:

- A definition of FWA.
- What information reporters should provide to assist in an investigation.
- How to report potential FWA.

For more information on FWA, please visit our CenCal Health website page on Fraud at http://www.cencalhealth.org/providers/suspect-fraud.

Q2 Fraud Waste and Abuse (FWA) Definitions

- Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. Fraud includes any act that constitutes fraud under applicable Federal or State law.
- Waste: The overutilization or inappropriate utilization of services and misuse of resources.
- Abuse: Activities that are inconsistent with sound fiscal, business, or medical practices, and result in the following: unnecessary cost to healthcare programs or reimbursement for services that are not Medically Necessary or fail to meet professionally recognized standards for healthcare. Abuse also includes beneficiary practices that result in unnecessary cost to healthcare programs.

Q3 Examples of FWA

In general, health care fraud costs the state and federal taxpayers billions of dollars each year, harming both patients and taxpayers. Below are examples of FWA that must be reported to CenCal Health

Member/Beneficiary:

- Failure to report other health coverage;
- Loaning, giving, or using another individual's identity, BIC, CenCal Health identification card, Medi-Cal number, or other documentation of Medi-Cal or CenCal Health eligibility to obtain covered services, unless such person is an authorized representative who is presenting such document or information on behalf of a member to obtain covered services for that member;
- Selling a member's identity, BIC, CenCal Health identification card, Medi-Cal number, or other documentation of Medi-Cal or CenCal Health's eligibility;
- Using a Covered Service for purposes other than the purposes for which it was prescribed or provided, including use of such Covered Service by an individual other than the member for whom the covered service was prescribed or provided;
- Soliciting or receiving a kickback, bribe, rebate, or other illicit incentive, as outlined in the Federal Anti-Kickback Statute, as an inducement to receive or not receive Covered Services; and,
- Impersonating a provider or falsifying provider documentation to obtain unauthorized items (e.g. prescription medications, durable medical equipment).

Provider:

- When an individual or provider recruits and pays individuals money or offers gifts in exchange for referrals in the Medicare or Medi-Cal program;
- A provider charging a Medicare or Medi-Cal beneficiary for the difference between the allowed reimbursement rate and the customary charge for the service;
- Billing for services not rendered;

- Billing for services at a frequency that indicates the provider is an outlier as compared with their peers;
- Billing for non-covered services using an incorrect CPT, HCPCS and/or Diagnosis code in order to have services covered;
- Billing for services that are actually performed by another provider;
- Up-coding;
- Unbundling services that should be billed together;
- Billing for more units than rendered;
- Altering records to receive covered services.

Q4 Reporting Fraud, Waste or Abuse (FWA)

Under the terms of the contract between CenCal Health and the Provider, the Provider and Subcontractors are required to report suspected cases of FWA. CenCal Health supports good faith and anonymous reporting through a variety of reporting channels accessible to all employees, members, business partners, and the public without fear of retaliation.

When Reporting Fraud, Waste or Abuse please provide as much of the following information as possible (if available):

- Name, Address, License, or Insurance ID of suspect.
- Description and Details of the Incident: who, what, where, when, date and time of incident(s).
- Any documentation you may have related to the incident(s).
- Your name, telephone number (if you would like to be contacted).

Any person may report a suspected FWA matter to CenCal Health through the following mechanisms:

☎ By Telephone: Compliance Hotline (Anonymously): (866) 775-3944
The Compliance Hotline is available in both English and Spanish and can receive tips 24-hours a day, 7-days a week. The Compliance Hotline is operated by a third-party vendor to maintain confidentiality for the reporter.

By Fax: (805) 681-8279; ATTN: Compliance Department

By E-mail: compliance@cencalhealth.org

By Mail:

CenCal Health
Fraud Investigations
Compliance Department
4050 Calle Real
Santa Barbara, CA 93110

By Compliance Alert Line: https://cencalhealth.alertline.com/gcs/overview
CenCal Health Chief Compliance Officer: (877) 814-1861

You may also report FWA to the following external agencies, directly:

Department of Health Care Services (DHCS)

Phone: (800) 822-6222
Online: http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

California Department of Justice, Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA)

Phone: (800) 722-0432
Online: https://oag.ca.gov/bmfea/reporting

Office of Inspector General:

Phone: (800) HHS-TIPS (800-447-8477)
Online: https://oig.hhs.gov/fraud/report-fraud

Q5: Health Insurance Portability and Accountability Act (HIPAA):

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that requires CenCal Health and its network Providers to protect the security and maintain the confidentiality of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights.

PHI is any individually identifiable health information, including demographic information. PHI includes but is not limited to a member's name, address, phone number, medical information, social security number, ID card number, date of birth, and other types of personal information.

This section of the Provider Manual seeks to guide Providers on the following:

1) implementation of safeguards to protect CenCal Health member PHI;
2) ensure appropriate uses and disclosures of PHI;
3) ensure members are able to timely access their own PHI; and
4) how to identify and report privacy incidents and breaches to CenCal Health.

Safeguarding PHI

As HIPAA covered entities, CenCal Health and its Providers must comply with HIPAA requirements. Below are a few reminders on how to protect and secure PHI:

PHI in Paper Form

- Documents containing PHI should not be visible or accessible to visitors or others who are unauthorized to have access to PHI.
- When faxing documents containing PHI, verify the recipient, the recipient's fax number, and the documents being sent.
- Ensure that outgoing faxes include a fax cover sheet that contains a confidentiality statement.
- When mailing PHI, verify the recipient, the recipient's mailing address, and the documents being sent.
- Ensure that envelopes and packages are properly sealed, secured, and if using a clear window envelope, ensure that information is not visible through the window of the envelope, prior to mailing out.
- When transporting PHI, ensure that the information is protected by using binders, folders, or protective covers.
- PHI must not be left unattended in vehicles.
- PHI must not be left unattended in baggage at any time during traveling.
- PHI should be locked away during non-business hours.
- PHI must be properly disposed of by shredding. Never recycle or dispose of documents containing PHI in the trash bin.

PHI in Electronic Form

- When transmitting PHI via email ensure that the email is encrypted. This prevents anyone other than the intended receiver from obtaining access to the PHI.
- Do not include PHI such as an individual's name or Beneficiary ID number (CIN) in the subject line of the email.
- Confirm the recipient, recipient's email address, and documents or information being sent, prior to sending the email.
- Ensure all portable data storage devices (CDs, DVDs, USB drives, portable hard drives, laptops, etc.) are encrypted.

PHI in Oral Form

- Do not discuss PHI in public areas such as the patient waiting room.
- Do not discuss PHI with unauthorized people. Always verify the identification of an individual, prior to discussing PHI with the individual.
- Ensure to speak quietly when discussing PHI.

Uses and Disclosures of Member PHI

The HIPAA Privacy Rule allows member PHI to be used and disclosed without the member's written consent for the following reasons (not a complete list):

- Verifying eligibility and enrollment
- Authorization for Covered Services
- Claims processing activities
- Member contact for appointments
- Investigating or prosecuting Medi-Cal cases (e.g. fraud, waste, or abuse)

- Monitoring Quality of Care
- Medical treatment
- Case Management/Disease Management
- Providing information to public health agencies as permitted by law
- In response to court orders or other legal proceedings
- Appeals/Grievances
- Requests from State or federal agencies or accreditation agencies

Providers must obtain specific written consent through a HIPAA Compliant Authorization Form for all other uses and disclosures of PHI that do not fall within the list above or are otherwise permitted by the HIPAA Privacy Rule.

Member Access to PHI
The HIPAA Privacy Rule requires CenCal Health and its Providers to provide members, upon request, with access to their PHI. Providers must ensure that their medical records systems allow for prompt retrieval of medical records and that these records are available for review whenever a member requests access to their PHI. Providers must also ensure to provide the member with both timely access to their PHI and provide the PHI in the form and format requested by the member.

Reporting of Privacy Incidents and Breaches to CenCal Health
The HIPAA Breach Notification Rule, requires CenCal Health and HIPAA covered entities to provide notification following a breach of PHI. Providers must immediately, within 24 hours from discovery report both privacy incidents and breaches involving CenCal Health members to CenCal Health.
A privacy incident is defined as an event or situation where an individual or organization has suspicion or reason to believe that PHI may have been compromised. Privacy incidents include but are not limited to the following:

- PHI sent to the wrong individual or organization.
- PHI being sent unencrypted.
- Loss or theft of documents containing PHI.
- Loss or theft of unencrypted devices (laptop, hard drives, USB drives).

A breach is defined as an unauthorized access, use, or disclosure of PHI that violates either federal or state laws or PHI that is reasonably believed to have been acquired by an unauthorized person.

Timely reporting of incidents and breaches involving the PHI of our members is crucial in the response, investigation, and mitigation of incidents and breaches. To report suspected or known privacy incidents and breaches you may contact CenCal Health through any of the following means.

☎ Phone: Anonymous Compliance Hotline: 866-775-3944

Fax: 805-681-8279

E-mail: HIPAATeam@cencalhealth.org

Mail: CenCal Health
Attn: Privacy Office
4050 Calle Real
Santa Barbara, CA 93110

Section R: Forms Library

Claims

www.cencalhealth.org/providers/claims/corrections-disputes-appeals/

- Provider Dispute/Appeal Resolution Request
- Date of Service Claim Correction Form

Facility Site Review

www.cencalhealth.org/providers/facility-site-review/

- Site Review Guidelines
- Medical Record Review
- Physical Accessibility Review Survey (PARS)
- Posting for Doctor's Office
- Medical Waste Mailback Sources
- Tuberculosis (TB) Risk Assessment - Adults
- Tuberculosis (TB) Risk Assessment - Children
- Hearing and Vision Screening
- Sharps Injury Log
- Emergency Medication Dosage Chart
- Medi-Cal PCP Facility Site Review & Medical Record Review Preparation
- Interim Facility Site Review (Fax Back)
- Your Right To Make Decisions About Medical Treatment
- About the Staying Healthy Assessment (SHA)
- Staying Healthy Assessment (SHA)
- Alternative Medical Waste Treatment Technologies
- Recommended Adult Immunization Schedule
- Recommendations for Preventive Pediatric Health Care
- Medication Check Log
- Temperature Log for Refrigerator – Fahrenheit
- Temperature Log for Freezer – Fahrenheit
- Referral Log
- Management of Anaphylaxis

Advisory Committee on Immunization Practices
Vaccine Administration Record for Adults