CenCal HEALTH
Local. Quality. Healthcare.

Section E: Covered Benefits and Services ... 2

E1: Covered Services Overview ... 2

E2.1: Acupuncture Services ... 3

E2.2: Audiology Services ... 4

E2.3: Chiropractic Services ... 5

E2.4: Hearing Aids Services ... 6

E2.5: Home Health Services ... 6

E2.6: Hospice Services ... 7

E2.7: Incontinence Supplies ... 7

E2.8: Laboratory Services ... 9

E2.9: Lactation Services ... 9

E2.10: Nursing Facility ... 9

E2.11: Nutrition Educators ... 10

E2.12: Optician Services ... 11

E2.13: Optometry Services ... 11

E2.14: Vision Services ... 12

E2.15: Physical Therapy Services ... 12

E2.16: Emergency Medical Transportation Services ... 13

E2.17: Durable Medical Equipment ... 14

E2.18: Medical Supplies ... 15

E2.19: Occupational Therapy ... 16

E2.20: Orthotics and Prosthetics ... 18

E2.21: Speech Therapy ... 20

E2: Limited Services ... 23

E3: Adult Preventive Services ... 24

E4: Pediatric Preventive Services ... 25

E5: Child Health and Disability Prevention (CHDP) Program ... 26

E6: Behavioral Health Treatment ... 27

E7: Mental Health Services ... 32

E8: Substance Use Services ... 44

E9: Non-Emergency Medical Transportation Services and Non-Medical Transportation ... 47

E10: Oral Health ... 49

E11: Postpartum Care ... 51

E12: Steps to Take for Tobacco Cessation ... 52

CenCal HEALTH®
Local. Quality. Healthcare.

E13: Whole Child Model (WCM) and California Children's Services (CCS) 54
E14: Community-Based Adult Services (CBAS) 55
E15: Palliative Care 56
E16: Diabetes Prevention Program 58
E17: Blood Lead Level Testing in Children 59
E18: Medical Pharmacy, Authorizations for Physician-Administered-Drugs (PADs) 60
E19: Doula Services 61
E20: Community Health Worker Services 64

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

CenCal Health is responsible for the provision of and access to the programs and Covered Services listed below, and as further detailed in CenCal Health's policies and procedures. 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
- Sexually transmitted disease services
- HIV testing and counseling
- Pregnancy termination and abortion services
- Nurse midwife and certified nurse practitioner services
- Lab tests and X-rays
- Prenatal care
- Immunizations
- Durable medical equipment
- Medical supplies
- Prosthetics and orthotics
- Pediatric preventive services (CenCal Health CHDP Program)
- Minor consent services
- 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
- Non-Specialty Mental Health Services (NSMHS) for minors
- Behavioral Health Treatment (BHT)
- Medication for Addiction Treatment (MAT)
- Palliative Care
- Indian Health Services programs

CenCal Health Policy Reference:
PS-CR30 – Access to Programs/Covered Services

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).

CenCal HEALTH®
Local. Quality. Healthcare.

Authorizations

Acupuncture services are subject to the limited two-services per month. Additional services may be provided based upon medical necessity through the TAR process. For further instructions on TAR's, please refer to Authorization Section H 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 they practice.

"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 by the Santa Barbara Health Initiative (SBHI) and 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 do not benefit 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.

Members enrolled in California Children's Services (CCS) have specific guidelines for audiology and hearing aid benefits. Please refer to CCS Numbered Letter 11-0807.
https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

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: 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 by the Santa Barbara Health Initiative (SBHI) and 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.
- 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, they 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.

CenCal HEALTH
Local. Quality. Healthcare.

E2.4: Hearing Aids Services

Services provided by Hearing Aid providers are covered by the Santa Barbara Health Initiative (SBHI), and the San Luis Obispo Health Initiative (SLOHI) and according to the California Code of Regulations (22 CCR 51319) for Hearing Aids.

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

Covered Hearing Aid Services

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 differs 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) and 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 are 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 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 the 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 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.

CenCal Health Policy Reference:

MM-UM11 – Hospice Services

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 guidelines below 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 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 and 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. Still, 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 are 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.

CenCal HEALTH
Local. Quality. Healthcare.

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 by the Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) and 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, including genetic and alpha-fetoprotein testing.
- Outpatient hospital and other outpatient facilities: Diagnostic services includes laboratory services.
- Inpatient hospital services: including laboratory services.
- Diabetes management and treatment, including outpatient services and laboratory testing.
- 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

A 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 that 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 in need of breastfeeding information. The focus of these lactation consultations is to assess the woman’s ability to breastfeed and resolve issues they may have related to 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 that 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 meets 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.

CenCal Health Policy Reference:
MM-UM30 – Long Term Care

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 the normalization of eating patterns and nutritional status and assist with medical monitoring in collaboration with the rest of the treatment team.
    - Nutritional services for members with an eating disorder, irrespective of whether the member is receiving outpatient mental health services through CenCal Health or county mental health.
- 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.

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 2 hours per 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
https://www.cencalhealth.org/wp-content/uploads/2021/10/202104rafexceptionslist.pdf

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.

The types 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 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 include:

- 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 and eyeglasses when necessary, every two (2) years. A referral from the member's PCP is not necessary.

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. All eyeglasses

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

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 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 the 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 who accepted responsibility for the member.

CenCal Health Policy Reference:

MM-UM33 - Emergency Medical Transportation, Non-Emergency Medical Transportation, and Non-Medical (EMT NEMT NMT)

CenCal HEALTH
Local. Quality. Healthcare.

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 per California law (California Code of Regulations - 22 CCR 51321), 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, 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 within 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 the contracted provider is unable to provide the service, CenCal Health will 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.

CenCal HEALTH®
Local. Quality. Healthcare.

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 are 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 update your email address, please contact the Provider Services Department at (805) 562-1676.

E2.19: Occupational Therapy

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)
- A 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 their 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

Occupational 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 a 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 Evaluation descriptions below. For additional information on billable procedure codes and rates, please reference DHCS Provider Medi-Cal Manual online at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?q=Medi-Cal%20rates&search=Medi-Cal%20rates

Description
Communication board, non-electric AAC devise
Evaluation-initial 30 minutes, plus report
Case conference and report-initial 30 minutes
Case conference and report-each additional 15 minutes
Occupational therapy preliminary evaluation rehabilitation, Nursing Facility (NF) B, NF-A
Treatment-initial 30 minutes
Treatment-each additional 15 minutes
Home or long-term care facility visit-add
Home or long-term care facility visit-add
Unlisted service
Case consultation and report

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 receiving payment for submitting claim forms to CenCal Health. Orthotics and Prosthetics services will be considered in accordance with the California Code of Regulations (22 CCR 51315)

“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 they have 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 their 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 CenCal Health members

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 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 Health 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 their 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 the 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 in the 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 the 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"

Procedures Codes

For additional information on billable procedure codes and rates, please reference DHCS Provider Medi-Cal Manual online at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?q=Medi-Cal%20rates&search=Medi-Cal%20rates

Description
Communication board, non-electric AAC device
Speech-generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time
Speech-generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
Speech-generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
Speech-generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
Speech-generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with device.
Speech-generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
Speech-generating software program for personal computer or personal assistant
Accessory for speech-generating device, mounting system
Accessory for speech-generating device, not otherwise classified
Language evaluation
Speech evaluation

Speech-language evaluation (group), each patient
Speech-language therapy, individual, per hour (following procedures H4300 or H4301)
Speech-language therapy, individual, ½ hour
Out-of-office call (payable only for visits to the first patient receiving services at any given location on the same day)
Speech therapy preliminary evaluation, rehabilitation, SNF, ICF
Speech-generating device (SGD)-related bundled speech therapy service, per visit
Speech-generating device (SGD) recipient assessment
Unlisted speech therapy service

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 the 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 by 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 Services 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, Occupational Therapy, Speech Therapy, and Audiology services will be limited to evaluation and treatment services, durations, and frequency of visits that are reasonable and medically necessary. Services will be subject to authorization and must be in accordance with the California Code of Regulations (*22 CCR 51309, Psychology, Physical Therapy, Occupational Therapy, Speech Pathology and Audiological Services)*

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 refer to Authorization Section H of the Provider Manual.

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 requires the provision of all preventive health services and medically necessary diagnostic and treatment services for adults in accordance with the most recent United States Preventive Services Task Force (USPSTF) "Guide to Clinical Preventive Services."

Additionally, CenCal Health requires the provision of immunization for adult members in accordance with the most recent adult immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). CenCal Health requires Primary Care Physicians or Advanced Practice Providers to make available this core set of preventive services consistent with the USPSTF and ACIP standards. Copies of these guidelines are available from CenCal Health upon request. Both documents are posted on CenCal Health's Preventive Health Guidelines website page.

Preventive services shall include all medically necessary diagnostic, treatment, and follow-up services, which are necessary given the findings or risk factors identified in the initial health appointment or during visits for routine, urgent, or emergent health care situations. Follow-up services should be initiated as soon as possible but no later than 60 calendar days following the discovery of a problem. Preventive services shall be age-appropriate and may include:

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

Assessment of medically necessary preventive services may be done at any opportunity, but at least during the initial health appointment and routine annual visits thereafter. Routine screenings and preventive services may be included in a provider's capitation or FFS payment. If uncertain, to verify whether a particular screening test is separately billable, please contact a CenCal Health Claims Representative at (805) 562-1083.

CenCal Health requires the provision of age and risk appropriate vaccinations in accordance with the findings of the initial health appointment (IHA) or other preventive screenings. Providers shall document in the members' medical records the receipt of vaccinations and report such information to immunization registries in CenCal Health's service areas in accordance with applicable state and federal laws. Additional details regarding IHA requirements can be found in *Section L7 – Initial Health Appointment*.

If preventive services or vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's medical record which indicates the services were advised, and the Member's or guardian of the Member's voluntary refusal of the services. If preventive services or vaccinations cannot be given at the time of the visit, then medical record entries must demonstrate that the Member was informed how to obtain necessary services, or appropriately referred, or scheduled for an appointment to receive services timely.

CenCal Health updates and publishes the Preventive Health Guidelines (PHG) annually in the *Health Matters/Temas de Salud* member newsletter. CenCal Health also includes the PHG documents in the Member Handbook/Evidence of Coverage and conducts outreach to all Members due for a preventive healthcare visit.

New members are also encouraged to make an initial health appointment within 120 days of enrollment.

CenCal Health Policy Reference:
PS-CR32 Adult Preventive Services

Reference Link:
CenCal Health Preventive Health Guidelines For Adults (English/Spanish Handout)
https://www.cencalhealth.org/members/medi-cal/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 Preventive Health Guidelines
https://www.cencalhealth.org/providers/care-guidelines/preventive-health-guidelines/

All Plan Letter (APL) 22 – 030:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf

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) and DHCS guidelines (APL 23-005, *Requirements for Coverage of Early And Periodic Screening, Diagnostic, and Treatment Services for Medical Members Under the Age of 21*). 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 the 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."

The CHDP Program will be discontinued effective July 1, 2024, per the Department of Healthcare Services. CHDP services will be covered through CenCal Health's delivery system. Please refer to Section E of the Provider Manual for Covered Benefits and Services.

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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Behavioral Health Treatment (BHT) services for the treatment of Autism Spectrum Disorder include Applied Behavior Analysis (ABA), and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of the beneficiary, including those with or without a diagnosis of ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

CenCal Health ensures that all of a member's needs for Medically Necessary BHT services are met across environments, including on-site at school or during virtual school sessions. Educationally necessary BHT services covered by a Local Educational Agency (LEA) and provided pursuant to a Member's Individualized Family Service Plan (IFSP), Individualized Education Program (IEP), or Individualized Health and Support Plan (IHSP) may be covered if Medically Necessary. Additionally, CenCal Health provides supplementary BHT services to address any gap in service caused when the LEA discontinues the provision of BHT services.
A member may meet eligibility for medically necessary Behavioral Health Treatment Services if all of the following criteria are met:

- The member is less than 21 years of age.
- The member is medically stable.
- The member is not in need of 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 as Medically Necessary by a licensed physician, surgeon, or psychologist as medically necessary, regardless of diagnosis.

CenCal HEALTH
Local. Quality. Healthcare.

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 service 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.

Criteria for Services for Members Under the Age of 21

CenCal Health uses clinical criteria and guidelines to determine what services are medically necessary. Each authorization request is reviewed appropriately with the member's medical needs for BHT services in accordance with EPSDT requirements and medically necessary standards of care.

Covered Services

BHT services must be:

1. Medically Necessary
2. Provided and supervised in accordance with a CenCal Health approved behavioral treatment plan that is developed by a BHT service provider who meets the requirements in California's Medicaid State Plan; and,
3. Provided by a qualified autism provider who meets the requirements contained in California's Medicaid State Plan or a licensed provider acting within the scope of their licensure.

The following activities are considered non-covered services:

1. Training of staff
2. 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 is to actively provide treatment, not to just supervise, control, or contain the member/identified client.
3. 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.
4. Assisting the member with academic work, functioning as a tutor, or functioning as an educational aide for the member/identified client in school/daycare or at home.
5. Provider travel time.
6. Transporting parents or other family members.

Medi-Cal does not cover the following as BHT services under the EPSDT benefit:

1. Servies rendered when continued clinical benefit is not expected, unless the services are determined to be Medically Necessary.
2. Provision or coordination of respite, daycare, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person (hereinafter, "Guardian") for costs associated with participation under the behavioral treatment plan.

3. Treatment where the sole purpose is vocationally or recreationally based.
4. 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.
5. Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
6. Services rendered by a parent or legal custodian.
7. Services that are not evidenced-based behavioral intervention practices.

Recommendation and Authorization Process

- An ABA recommendation is required to start the Functional Behavioral Assessment Process with a BHT provider.
- Qualified Providers who meet criteria for recommending BHT services as medically necessary, for any member who is eligible, can submit an ABA Recommendation (RAFB) to the Behavioral Health Department via fax (805) 681-3070, Provider Portal or the Behavioral Health Department secure link.
- Upon completion of the FBA assessment, the BHT provider will submit a Treatment Authorization Request (50-1) to CenCal Health 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
- Timelines for authorization of treatment services are in accordance with standard Medi-Cal guidelines as described in Section H, H7: Timeliness for Authorization Request
- No more than one month and at least 14 days prior to the end of the authorization period, providers should submit a Behavioral Health 50-1 Treatment Authorization Request Form with an updated progress report using an approved template & service log to continue services.
  - 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 the provision of services that are less than hours approved by CenCal through Service Logs and Progress Reports.

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

- Credible studies and industry standards support that parent participation is associated with improved outcomes. Providers are responsible for coordinating 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 or duplicated. 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 is 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 may be requested.
- 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 to 10 units over the authorization period.

  a. Indirect supervision requests are part of the 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 who meet eligibility criteria for BHT services will be authorized by CenCal for an FBA and the 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.
  - Additional assessment hours must be requested with clinical documentation to support medical necessity.
- The initial authorization to complete an FBA will be for 60 days.
  - Providers may request an extension of up to 60 days by submitting a Behavioral Health 50-1 Treatment Authorization Request Form with the referral number via secure link or by fax to the Behavioral Health Department at (805) 681-3070.
- Providers must use at least one industry-approved cognitive and adaptive testing tools to assess the member's age-specific impairments on the FBA.
  - Examples: Vineland, Adaptive Behavioral Assessment System-ABAS, Developmental Assessment of Young Children (DAYC), Social Responsiveness Scare, and Social Emotional Learning Edition (SSIS SEL).
- In the event of a disruption of BHT services lasting 4 or more months, CenCal will approve another FBA.
- 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 first appointment offered, the date of first appointment scheduled, and reason for the difference between offered and scheduled appointments.
- Providers must document all outreach efforts to the parents to schedule the initial appointment. Providers who 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 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.

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 states 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, 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, in the home, or other community settings, must be clinically indicated, Medically Necessary and delivered in the most appropriate setting for the direct benefit of the member. BHT service hours delivered across settings, including during school, must be proportionate to the member's medical need for BHT services in each setting.
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 the maximum benefit of services. BHT providers will complete a discharge summary on CenCal Health's 6-month progress report template (or an approved template) and submit to the CenCal Health BH Department.

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 duplicated.

Behavioral Health Treatment Providers are responsible for coordinating care with the primary care physician, other providers, and entities closely involved with the member's care.

Medically Necessary BHT services are not considered duplicative when CenCal Health has overlapping responsibility with another entity for the provision of BHT services unless the services provided by the other entity is currently being provided, is the same type of service, addresses the same deficits, and is directed to equivalent goals.

Coordination of care activities may include the following:

- Contacting the member's pediatrician if the 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.
  - CenCal Health contracted providers may determine that BHT services included in a member's IEP are no longer Medically Necessary.
- 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

CenCal Health Policy Reference:

MM-BH300 Behavioral Health Treatment
HS-UM07 Pre-Service Review
HS-UM37 Coordination of Care for Local Education Agency Services

E7: Mental Health Services

Non-Specialty Mental Health Services (NSMHS) are a covered benefit for CenCal Health members when medically necessary. They 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 with a member to establish medical necessity for medication management of a psychiatric or behavioral disorder.

Services are covered by CenCal Health even when:

- Services are provided prior to the determination of a diagnosis, during the assessment period, or prior to the 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 the 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 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.

CenCal HEALTH®
Local. Quality. Healthcare.

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 include all DSM V diagnoses as primary focus of treatment **except** neurocognitive disorders, substance-related and addictive disorders.

Services are covered if these diagnoses are co-occurring with a mental health disorder and meet criteria for Non-Specialty Mental Health Services.

Authorizations & Referral Protocols

- Referrals and Authorizations are not required for psychotherapy or medication management services.
- Prior Authorization is required for psychological and neuropsychological 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 clinically indicated and medically necessary.
    - Rendering/Servicing providers are responsible for submitting 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 choose to seek and obtain a mental health assessment from a licensed mental health provider at any time.
- Members with positive screening results may be further assessed by their Primary Care Physician or referred to a network mental health provider.
- When the condition is beyond the Primary Care Physician's scope of practice, the primary care provider must refer to a contracted mental health provider first.
- If a member's Primary Care Physician cannot perform the mental health assessment, they must refer the member to an appropriate contracted provider and ensure that a closed loop referral is documented (the member is ensured access, a date/time of appointment is obtained, and the member is followed up to ensure they attended). CenCal Health's Mental Health Providers are required to use DHCS's required Transition of Care tool located on the Behavioral Health webpage.
- 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 mental health system of care.

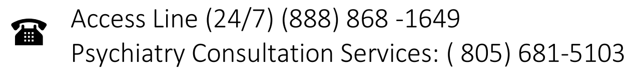
CenCal HEALTH
Local. Quality. Healthcare.

CenCal Contact Numbers

CenCal Health Behavioral Health Department

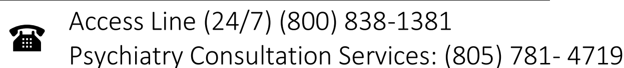
Member Line: (877) 814-1861
Provider Line: (805) 562-1600
Fax number: (805) 681-3070
Secure Link: https://gateway.cencalhealth.org/form/bh

Santa Barbara County Department of Behavioral Wellness



Access Line (24/7) (888) 868 -1649
Psychiatry Consultation Services: (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 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 the 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

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 the treatment plan be updated every 6 months for psychotherapy services and annually for medication management services.
- Treatment plans must be consistent with diagnoses and 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 their 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 member's PCP, including but not limited to arranging for referrals to other specialists, including psychological testing.

Referrals to Specialty Mental Health Services

Specialty Mental Health Services are delivered through the county mental health plan and are covered for members who meet the following criteria:

Members 21 years of age and over must meet both criteria 1 and 2:

- Criteria 1: The recipient has one or both of the following:
  - Significant impairment, where impairment is defined as distress, disability or dysfunction in social, occupational or other important services.
  - A reasonable probability of significant deterioration in an important area of life functioning.

- Criteria 2: The recipient's condition in criteria 1 is due to either one or the following:
  - A diagnosed mental health disorder, according to the criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases and Related Health Problems.
  - A suspected mental disorder that has not yet been diagnosed.

Members under 21 years of age must meet either criteria 1 or 2 below:

- Criteria 1: The recipient has a condition putting them at high risk for a mental health disorder due to experiencing trauma evidenced by at least one of the following:
  - Scoring in the high-risk range on a trauma screening tool approved by Medi-Cal.
  - Involvement in the child welfare system
  - Juvenile justice involvement
  - Experiencing homelessness
- Criteria 2: The recipient meets both requirements A and B:
  A. The recipient has at least one of the following conditions:
     - A significant impairment
     - A reasonable probability of significant deterioration in an important area of life functioning.
     - A reasonable probability of not progressing developmentally as appropriate.
     - A need for SMHS, regardless of the presence of impairment, which is not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

  B. The recipient's condition in requirement A above is due to at least one of the following:
     a. A diagnosed mental health disorder, according to the criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
     b. A suspected mental health disorder that has not yet been diagnosed.
     c. Significant trauma placing the recipient at risk of a future mental health condition, based on the assessment of a licensed mental health professional.
- Medi-Cal requires referring clinicians to complete the Transition of Care Tool for Medi-Cal Mental Health Services when referring members who are receiving services from CenCal Health delivery system to the County's delivery system or adding on services within the other delivery system.
- The decision to transition services to and/or add services must be made by a clinician via a patient-centered shared decision-making process in alignment with CenCal Health's policies. Members must be engaged in the process and appropriate consents must be obtained in accordance with standards of clinical practice.
- The Transition of Care Tool may be completed in person, by phone, or by video conference by a clinician or non-clinician. The decision to refer must be made by a clinician.
- Additional clinical information may be attached, including medical history reviews, care plans or medication lists.
- Referring providers must continue to provide services during the transition period and until the member is connected with a Provider in the new system of care, the provider accepts the new member and medically necessary services have been made available to the member.
- Once referred, CenCal Health Behavioral Health Department will provide updates on the members initial intake assessment date with the County Health Plan.

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 once 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

Psychiatric Diagnostic Evaluation

CPT Code 90791 may be used to bill for psychiatric evaluation without medical services, and 90792 to bill for psychiatric diagnostic evaluation with medical services. Psychiatric diagnostic evaluation must be consistent with the scope of license and competency of the mental health provider and must be documented in the medical record with the following items included:

- Presenting problem/changes in functioning and history of presenting concern
- Mental health and substance use history
- Medical history and current medications
- Social and cultural factors
- Risk and safety factors
- Case conceptualization and diagnostic summary

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.

Psychotherapy

Individual, family, and group psychotherapy that is evidence-based or incorporates evidence-based components is reimbursable for eligible members.

Individual Therapy

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; please use diagnosis code F99.

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.

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 or for members under the age of 21 who are at risk for behavioral health concerns and for whom clinical literature would support that the risk is significant such that family therapy is indicated but may not have a mental health diagnosis.
- All family members do not need to be present for each session.
- Members under age 21 are entitled to receive up to five family therapy sessions before a mental health diagnosis is required.
- Any diagnostic criteria used should be age-appropriate. (i.e., Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood).
- Family therapy is composed of at least two family members receiving therapy together provided by a mental health provider to improve parent/child or caregiver/child relationships and encourage bonding, resolving conflicts, and creating a positive home environment. The primary purpose of family therapy is to address family dynamics as they relate to the member's mental status and behavior(s).
    - Members under age 21 with a diagnosis of a mental health disorder.
    - Members under age 21 with persistent mental health symptoms in the absence of a mental health disorder.
    - Members under the age of 21 with a history of at least one of the following risk factors:
        - Neonatal or pediatric intensive care unit hospitalization
        - Separation from a parent or caregiver
        - Death of a parent or caregiver
        - Foster home place placement
        - Food insecurity, housing instability
        - Maltreatment
        - Severe and persistent bullying

- Experience of discrimination, including but not limited to discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability; or
- Members under the age of 21 who have a parent(s) or caregiver(s) with one or more of the following risk factors:
  - A serious illness or disability
  - A history of incarceration
  - Depression or other mood disorders
  - Post-Traumatic Stress Disorder or other anxiety disorder
  - Psychotic disorder under treatment
  - Substance use disorder
  - Job loss
  - A history of intimate partner violence or interpersonal violence
  - Is a teen parent

Family therapy is also reimbursable on an inpatient basis if the member is an infant (under 1 year of age) who is 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.

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

Reimbursable family therapy models include, but are not limited to:

- Child-Parent Psychotherapy (ages 0 through 5)
- Parent-Child Interactive Therapy (ages 2 through 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 is expected to be at least one and one-half hours in duration.

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. Psychotherapy add-on codes to E/M services: (CPT 833, 936, 938). Providers must clearly document in the member's medical record the time spent providing psychotherapy services. In other words, time spent 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 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.

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 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 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.

Claims billed with CPT codes 96105, 96116, and 96121 must include an attachment specifying the amount of time spent completing each of the following:

- Administration of test(s)
- Interpretation of test results
- Preparation of the report

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

CenCal Health Policy Reference:
MM-BH301 Mental Health Services
HS-UM38 Authorization for Psychological Testing for Mental Health Conditions

CenCal HEALTH
Local. Quality. Healthcare.

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, and pregnant members. These services are covered in the primary care settings and the tobacco, alcohol, and illicit drug screening are completed in accordance with the 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's Drug Medi-Cal Organized Delivery System (DMC-ODC). For Members receiving alcohol or Substance Use Disorder services through the County's Alcohol and Drug Programs, 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's DMC-ODC/Alcohol and Drug Programs.

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 is considered to ameliorate a substance use condition.

Covered Services

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

- SABIRT services for members 11 years of age and older, including pregnant women.
- 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 the 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 screening 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)

The AAP recommended assessment tool is available at http://crafft.org.

Brief Interventions and Referral to Treatment

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

CenCal Health reimburses alcohol and/or drug brief intervention 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.

CenCal Health providers must make good faith efforts to confirm whether members received treatment and document when, where, and any next steps following treatment. If a member does not receive referred treatment, providers should follow up with the member to understand barriers and adjust referrals, if warranted.

CenCal Health providers should also attempt to connect with the provider to whom the member was referred to facilitate a warm hand-off to necessary treatment.

- CenCal Health Behavioral Health Department can assist providers in coordinating substance use treatment referrals. 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.

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:

- Members can self-refer or can be referred by a CenCal Health provider by calling the 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:

- Members can self-refer or can be referred by a CenCal provider by calling County ACCESS line at (888) 868-1649 and ensuring 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.

CenCal Health Policy Reference:
MM-BH 303 Access to NSMHS, SUD and Referral Completion and Tracking

CenCal HEALTH
Local. Quality. Healthcare.

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

Non-Emergency Medical Transportation (NEMT) services are available 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. Services will be in accordance with DHCS Guidelines (APL 22-008, *Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses*).

NEMT requires prior authorization (TAR). A completed and signed 'Physician Certification Statement' (PCS) form is required to authorize NEMT. The PCS 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 Statement' form must include *all required fields:*

a) **Functional Limitations and Justification:** 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.
e) **Diagnosis:** The physician is required to state the member's diagnosis.

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 the 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 for ensuring 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 the NMT request is determined 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.

CenCal Health Policy Reference:
MM-UM33 - Emergency Medical Transportation, Non-Emergency Medical Transportation, and Non-Medical (EMT NEMT NMT)

E10: Oral Health

Oral health is crucial to the overall health and well-being of infants, children, and adolescents. Tooth decay is one of the most common chronic diseases of childhood. Poor oral health leads to pain, school absenteeism, and an overall negative effect on children's general physical health.

All members less than 21 years of age are required to receive a dental screening and an oral health assessment as part of every periodic assessment, with annual dental referrals beginning with the eruption of the member's first tooth or at 12 months of age, whichever occurs first.

According to The American Academy of Pediatric Dentistry (AAPD), a child should be seen by a dentist starting at 12 months of age and every 6 months thereafter or according to a schedule recommended by the dentist. The care and schedule should be based on the child's individual needs and susceptibility to disease.
If a dental home is unavailable, the child's Primary Care Provider (PCP) or assigned staff should *apply topical fluoride varnish to patients every 6 months.* In the absence of a dental home program that can see a child between the ages of 1 and 4, the PCP should continue to perform oral health risk assessments. The AAPD recommends that health care professionals use the AAP Oral Health Risk Assessment Tool.

Topical application of fluoride varnish is a covered benefit for pediatric CenCal Health members. The U.S Preventive Services Task Force recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk.

Fluoride varnish 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.

PCPs or trained nurses and medical assistants under the supervision of an ordering provider have an opportunity to help prevent tooth decay by applying fluoride varnish.

Billing for Fluoride Varnish
Use **CPT code 99188** - topical application. Reimbursable for children through age 5.
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 a school/health fair or government program

CenCal Health covers and ensures that dental screenings and oral health assessments are included for **all members**. This includes referrals to appropriate Medi-Cal dental providers, as well as Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional. Services exclusively provided by dental providers are not covered by CenCal Health. In addition, CenCal Health covers and ensures the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists, but may require prior authorization for medical services required in support of dental procedures.

For questions, please contact our Population Health Team at populationhealth@cencalhealth.org.

Monitoring
To ensure the completion and documentation of these requirements, CenCal Health staff perform randomized medical record audits throughout the year. Findings are shared and discussed with audited PCPs.

Annually, CenCal Health reports to DHCS the percentage of children ages 1 through 20 who received at least two topical fluoride applications within the measurement year.
See *Section L5: Performance Monitoring* for additional detail.

CenCal HEALTH®
Local. Quality. Healthcare.

Reference Link:

American Academy of Pediatric Dentistry Oral Health Risk Assessment Tool
https://downloads.aap.org/AAP/PDF/oralhealth_RiskAssessmentTool.pdf

Bright Futures/ AAP Health Promotion: Promoting Oral Health
https://downloads.aap.org/AAP/PDF/Bright%20Futures/BF4_OralHealth.pdf

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

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

DHCS All Plan Letter 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf

Fluoride Use in Caries Prevention in the Primary Care Setting
https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary?autologincheck=redirected

U.S. Preventive Task Force Recommendation
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1

DHCS Medi-Cal Accountability Set Reporting Year 2024
https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2024.pdf

E11: Postpartum Care

In alignment with The American College of Obstetricians and Gynecologists (ACOG), CenCal Health requires providers to ensure completion of the first postpartum care visit within the first three weeks after delivery, followed by individualized, ongoing care as needed, concluding with a comprehensive visit no later than 12 weeks after birth.

The time following birth is a critical time for the birthing person and the infant. To optimize the health and well-being of both, postpartum care should be an ongoing process, with services and support tailored to the patient's needs. More than 80 percent of pregnancy-related deaths are preventable, with most deaths occurring in the 7-365 days after childbirth.

During this postpartum time, the patient is adapting to multiple physical, social, and psychological changes, such as recovering from childbirth, adjusting to changing hormones, and learning to care for a new baby. This transition into what is called the "fourth trimester" can be full of happiness but can also be full of challenges; thus, timely postpartum care is essential to the health and well-being of the birthing person and the infant.

In accordance with the Centers for Medicaid and Medicare Services (CMS) toolkit, providers should follow-up on pregnancy and delivery complications such as gestational diabetes, cardiac and coronary conditions, infections, blood clots, and cardiomyopathy. An assessment of mental health, lactation education, and reproductive health counseling should be standard practice.

Additionally, the distribution of printed education resources should include government assistance programs such as Women, Infant and Children (WIC).

Recommendations

ACOG recommends:

- The first postpartum care visit should be completed within the first three weeks after delivery, followed by individualized, ongoing care as needed, concluding with a comprehensive visit no later than 12 weeks after birth.
- Individualized visits based on a full assessment of physical, social, and psychological well-being.
- For patients who experienced a miscarriage, stillbirth, or neonatal death, timely follow-up with an obstetrician-gynecologist is highly suggested.
- Gynecologists or Primary Care Providers should establish ongoing coordination of care for a birthing person with chronic medical conditions.
- Obstetricians and Gynecologists must utilize the most current standards or guidelines of American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) to ensure members receive quality perinatal and postpartum services.
- Obstetricians and Gynecologists must utilize a comprehensive risk assessment tool for all pregnant members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. The results of the risk assessment must be maintained in the member's record and must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit.

Billing

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 **initiated within 3 weeks after delivery, with ongoing care in accordance with the ACOG recommendations**. 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.

- CPT code Z1038

Doula Services

As of January 1, 2023, doula services are a covered Medi-Cal Benefit. CenCal Health members will now be able to get support from a doula (birth worker) at no cost for prenatal and postpartum visits as well as during labor and birth, miscarriage, and abortion visits. For a doula to be reimbursed for services, they need to be contracted with CenCal Health. For additional information, please reference Section E19: Doula Services of the manual, or contact the Provider Relations department at (805) 562-1676 or email psrgroup@cencalhealth.org

Referrals

Case Management referrals can be submitted for CenCal Health members. Please visit the CenCal Health website for steps on how to submit a referral: https://www.cencalhealth.org/providers/case-management/

For additional contractual requirements and questions, please contact CenCal Health's Population Health team: populationhealth@cencalhealth.org

Reference Link:

Centers of Medicaid and Medicare Services (CMS) toolkit: https://www.medicaid.gov/sites/default/files/2023-08/ppc-for-state-and-medicaid-toolkit.pdf

ACOG Clinical Guidelines
https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx

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.

CenCal HEALTH
Local. Quality. Healthcare.

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 the 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
     - Tobacco Use Codes: https://ctri.wiscweb.wisc.edu/wp-content/uploads/sites/240/2017/09/icd10.pdf
     - Vape/E-cigarette Use Codes: https://www.cdc.gov/nchs/data/icd/Vapingcodingguidance2019_10_17_2019.pdf
   - Place a chart stamp in the medical chart

3. If identified as a smoker, discuss smoking cessation regimens (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 the 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
     Individual counseling, or brief intervention, can be performed at your office visit and can include one of the following validated counseling methods:
     - 5 As (Ask, Advise, Assess, Assist, Arrange) https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.pdf
     - 5 Rs (Relevance, Risks, Rewards, Roadblocks, Repetition) https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5rs.pdf
     - Other methods of your choice

Billing:
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
  - https://kickitca.myshopify.com/collections/all
- Or log onto to Helpline's web referral to refer the patient directly. Helpline counselors will then contact patient's personal phone
  - https://www.kickitca.org/patient-referral

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:
International Classification of Diseases (ICD)-10 Codes
https://ctri.wisc.edu/wp-content/uploads/sites/240/2017/09/icd10.pdf

Five Major Steps to Intervention (The "5A's")
Treating Tobacco Use and Dependence - Five Major Steps to Intervention (The "5A's") (ahrq.gov)

Patients Not Ready To Make A Quit Attempt Now (The "5 R's")
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/guidelines-recommendations/tobacco/5rs.pdf

Kick It California
https://kickitca.myshopify.com/collections/all

https://www.kickitca.org/patient-referral

Agency for Healthcare Research and Quality Treating Tobacco Use and Dependence
https://www.ahrq.gov/prevention/guidelines/tobacco/clinicians/update/index.html

Department of Health Care Services APL 16-014
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 is in accordance with DHCS guidelines (APL 21-005, *California Children's Services Whole Child Model Program)* which 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. Methods to ensure timely access may include member assignment to a specialist as a PCP. In such case, the specialist would be required to fulfill the responsibilities and contractual requirements of a PCP, including completion of the Facility Site Review.

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, they 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) 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.

CCS Eligibility Annual Renewals

CCS eligibility has to be reviewed by the CCS Counties on an annual basis. Providers must send the most recent clinic visit notes and medical records to CenCal Health to ensure that authorizations to CCS specialists or Specialty Care Centers are renewed timely.

CenCal Health Policy Reference:
HS-MM45 - Provider Responsibilities for the Care of CCS and Whole Child Model Members

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/wp-content/uploads/2021/10/202104rafexceptionslist.pdf

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

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.

CenCal Health Policy Reference:
HS – MM56 - Community Based Adult Services (CBAS)

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 online cencalhealth.org/providers/provider-training-resources/provider-training-library/ .

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), and 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 a 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 lifestyle 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 and lifestyle coaches rendering for the provider organization must be specially 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 the 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

All providers who perform periodic health assessments (PHA) on members between the ages of six months to six years (i.e., 72 months) must ensure children are tested for blood lead levels (BLL) **at both 12 months and 24 months of age, and order catch-up testing if missed at either 12 or 24 months**. Federal law requires the testing of children enrolled in Medicaid for elevated blood lead levels as part of required preventive services offered through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. CenCal Health covers this test in accordance with the California Code of Regulations (CCR) to comply with federal and state laws.

Providers must assess and test children following the Bright Futures Periodicity Schedule published by the American Academy of Pediatrics. Upon blood lead testing, providers must follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when reporting and interpreting blood lead levels and determining appropriate follow-up activities, including referrals to the local public health department.

Providers must also:

- Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.
  - This anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.
- Document blood lead screening guidance and test results in the child's medical record.
- If the parent(s) or guardian(s) of a child member refuse the blood lead screen test, providers must include a signed statement of voluntary refusal by the member (if an emancipated minor) or the parent(s) or guardian(s) of the member in the child's medical record. If a signed statement is unable to be obtained, the provider must document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record.
  - A refusal form template is provided on the CenCal Health website.

Monitoring

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

On a monthly basis, CenCal Health monitors the prevalence and timeliness of blood lead testing in its membership, using the prevailing industry-standard methodology.
In accordance with DHCS contractual obligations, CenCal Health identifies members less than six years of age with no record of receiving a required lead test.

Providers will be notified monthly of all assigned members due for blood lead screen tests through gaps in care reports, as lead testing is one of the priority measures in CenCal Health's Quality Care Incentive Program (QCIP). These reports are available within the QCIP section of the Provider Portal.

Billing

Blood lead testing is a covered CenCal Health benefit. Providers can bill using CPT procedure code 83655.

For questions or support, please contact the Population Health team at populationhealth@cencalhealth.org

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

California Department of Public Health Requirements for Blood Lead Reporting
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx

CenCal Health Lead Testing Best Practices
https://www.cencalhealth.org/providers/care-guidelines/epsdt-services/lead-testing/

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

DHCS All Plan Letter 20-016: Blood Lead Screening of Young Children (Supersedes APL18-017)
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf

Publications for Healthcare Providers and Patients
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/Publications-for-Providers.aspx#

Standard of Care on Screening for Childhood Lead Poisoning
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/screen_regs_3.aspx

Statutes and Regulations
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/leg.aspx

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.

CenCal Health Policy Reference:
HS-UM07 Notification of Determination and Timeliness

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

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

CenCal HEALTH®
Local. Quality. Healthcare.

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 the 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 may be 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).

Non-Covered Services

Pregnant or postpartum beneficiaries as Medi-Cal Doula services are not covered under Medi-Cal:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Still and video photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure are not covered.

Doulas are not prohibited from teaching classes available at no cost to individuals, including Medi-Cal members to whom they are providing Doula services.

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

- Be at least 18 years old
- Provide proof of an adult/infant Cardiopulmonary Resuscitation (i.e., CPR) certification from the American Red Cross or American Heart Association
- Attest to have completed basic 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:
    - Certificate of completion for a minimum of 16 hours of training in the following topics:
      - Lactation support
      - Childbirth education
      - Foundations on the anatomy of pregnancy and childbirth
      - Nonmedical comfort measures, prenatal support, and labor support techniques
      - Developing a community resource list
    - Attest that they have provided support at a minimum of three births
  - o Experience:
    - Attest that they have provided services in the capacity of a doula either a paid or volunteer capacity for at least five years. The five years of experience in the capacity of a Doula must have occurred 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.

Authorization of Services

Any licensed practitioner may make recommendations for Doula services via a Treatment Authorization Request (TAR), which will include the following covered services and automatically approved by CenCal Health (visits are limited to one per day, per month):

- One initial visit of 90 minutes
- Up to eight additional 1-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 3-hour postpartum visits after the end of pregnancy

- During the postpartum period, an additional TAR is required if extra visits are medically necessary
- Additional recommendations can include up to nine additional 1-hour postpartum visits
- Authorization will be provided on an individual basis based on medical necessity

One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery, abortion, or miscarriage support. Extended three-hour postpartum visits do not require the member to meet additional criteria or receive a separate recommendation.

Additional recommendations from a physician or other healing arts licensed practitioners acting within their scope of practice are required if additional visits are medically necessary during the postpartum period, which can include up to nine (9) additional 1- hour postpartum visits and will be reviewed for authorization by CenCal Health.

Doula service documentation requirements

Doula service providers are required to document the dates and time/duration of services provided to CenCal Health members, which should also reflect information on the nature of the care and service(s) provided to support the length of time spent with the member that day. (For example, documentation might state, "Discussed childbirth education with the beneficiary and discussed and developed a birth plan for 1 hour."). This allows CenCal Health to provide documentation accessible to the DHCS.

Doula service billing code details

Doula service claims should be submitted with at least one (1) Social Determinants of Health (SDOH) diagnosis code, as the Provider Portal forms require completion of that section to process.
Contracted Doula providers may use these codes for services listed here when submitting claims to CenCal Health.

Prenatal and Postpartum Visits

- Z1032-XP – Extended initial visit 90 minutes
- Z1034-XP – Prenatal visit
- Z1038-XP – Postpartum visit
- T1032-XP – Extended postpartum Doula support, per 15 minutes

Labor and Delivery Support

- CPT® 59409-XP – Doula support during vaginal delivery only
- CPT 59612-XP – Doula support during vaginal delivery after previous caesarean section
- CPT 59620-XP – Doula support during caesarean section

Abortion or Miscarriage Support

- HCPCS T1033-XP – Doula support during or after miscarriage
- CPT 59840-XP – Doula support during or after abortion

Extended initial visit must be for 90 minutes to bill with procedure code Z1032-XP.

All visits are limited to one per day per CenCal Health member and only one Doula may bill for a visit provided to the same member on the same day, excluding labor and delivery.

One prenatal visit or one postpartum visit may be provided on the same day as labor and delivery (including stillbirth), abortion, or miscarriage support.

- Prenatal or postpartum visits billed on the same calendar day as labor and delivery, abortion, or miscarriage support may be billed by a different Doula

- For extended postpartum visits lasting at least three hours, Doulas may bill code T1032-XP (15 minutes per unit) for up to 12 units per visit, up to two visits (24 units) per pregnancy per member provided on separate days

Billing codes for support during labor and delivery are limited to once per pregnancy. Support during labor and delivery can be billed if this service is provided by a Doula provider, whether or not the delivery results in a live birth. Billing codes HCPCS code T1033 for miscarriage support and CPT code 59840-XP for abortion support are each limited to once per pregnancy.

Reference Link:
DHCS Master Publication
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/doula.pdf

Onboarding Packet
/www.cencalhealth.org/providers/join-our-network/credentialing-applications-and-forms/

Social Determinant of Health (SDOH)
cencalhealth.org/providers/social-determinants-of-health/

Doula All Plan Letter 23-024
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL-23-024.pdf

E20: Community Health Worker Services

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.

Covered Services

CenCal Health covers CHW services for members that meet criteria in accordance with CenCal Health Policy and DHCS requirements, which includes:

- Preventive health services to prevent disease, disability, and other health conditions or their progression to help prolong life and promote physical and mental health
- Screening and assessment not requiring a license and assists a beneficiary in connecting to appropriate services to improve their health
- Individual support or advocacy to assist a beneficiary in preventing the onset or exacerbation of a health condition, preventing injury, or violence
- Asthma Preventive to individuals with asthma, but evidence-based asthma self-management education and asthma trigger assessments may only be provided by asthma preventive service providers who have completed either a certificate from the California Department of Public Health Asthma
- Services may also address issues that include, but are not limited to:
  - Control and prevention of chronic conditions or infectious diseases
  - Mental health conditions and substance use disorders
  - Need for preventive services, perinatal health conditions
  - Sexual and reproductive health
  - Environmental and climate-sensitive health issues
  - Child health and development
  - Oral health
  - Aging

  - Health Education to promote the beneficiary's health or address barriers to physical and mental health care, including providing information or instruction on health topics
- Content must be consistent with established or recognized health care standards
- May include coaching and goal setting to improve a beneficiary's health or ability to self-manage health conditions
  - Health Navigation to provide information, training, referrals, or support to assist beneficiaries to:
    - Access health care
    - Understand the health care system
    - Engage in their own care
    - Connect to community resources necessary to promote a beneficiary's health
    - Address health care barriers, including connecting to medical translation/interpretation or transportation services
    - Address health-related social needs
- CHW Violence Preventive Services
  - Evidence-based, trauma-informed, and culturally responsive preventive services provided by an individual qualified through any of the pathways listed below for the purpose of reducing the incidence of domestic violence, violent injury or reinjury, trauma, and related harms and promoting trauma recovery, stabilization, and improved health outcomes
  - Violence prevention services may be provided to a parent or legal guardian of a CenCal Health member under the age of 21 for the direct benefit of the beneficiary, in accordance with a recommendation from a licensed provider
- Serviced for the direct benefit of the CenCal Health member must be billed under the beneficiary's Medi-Cal ID
- Services are covered by Medi-Cal as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law

If the parent or legal guardian of the beneficiary is not enrolled in Medi-Cal, the CenCal Health member must be present during a session.

CenCal Health will use data-driven approaches to determine and understand populations who should be prioritized for CHW services using social determinants 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 that 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

Servicing Provider

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.

Minimum Qualifications

- CHWs must have lived experience that aligns with and provides a connection between the CHW and the community or population being served
- This may include but is not limited to, lived experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation.
- Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background of one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

Supervising providers are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving.

CHWs are not required to enroll as a Medi-Cal providers and are therefore not subject to the requirements for Provider Credentialing/Re-Credentialing and Screening/Enrollment.

Training

- No established single standardized curriculum for training CHWs or their employers
- Complete 6 hours (minimum) of additional training annually

Certificate of Completion

- CHWs, not having one, must earn it within 18 months of their first visit to a Medi-Cal member
- Must have completed a training specific curriculum and able to successfully demonstrate their acquired skills

Work Experience Pathway Program (WEP)

- Demonstrated skills and practical training in core competencies, as determined by a Supervising Provider
- CHWs demonstrating qualifications through this program, but do not have a certificate, must earn one within one year of the first CHW visit provided to a Medi-Cal member
- Plan of Care
  - Written document developed by one or more licensed providers, including the support and services a CHW will provide to address ongoing member needs
  - CHWs may assist in developing a plan of care with the licensed provider

CenCal HEALTH®
Local. Quality. Healthcare.

Violence Prevention Professional (VPP)

Individuals only providing violence prevention services can obtain a Violence Prevention Professional (VPP) Certification, issued by Health Alliance for Violence Intervention or a certificate in gang intervention training from the Urban Peace Institute.

Supervising Providers

Supervising provider shall be an enrolled Medi-Cal provider who submits claims for CHW services, ensures they meet the qualifications, directly or indirectly oversees a CHW and their services delivered to Medi-Cal beneficiaries, and can be a licensed provider, a hospital, an outpatient clinic, a Local Health Jurisdiction (LHJ), or a Community-Based Organization (CBO).
Supervising provider can provide supervision, coaching, direct support, and leadership to CHWs through training, mentoring, and case conferencing.
CHWs can be supervised by a CBO or LHJ not having a licensed provider on staff, and do not need to be the same entity as the provider who made the written recommendation for CHW services, and do not need to be physically present at the location when CHWs provide services to the CenCal Health member.

Management and day-to-day supervision of CHWs includes the following:

- Employees may be delegated as determined by the supervising provider
- However, the supervising provider is responsible for ensuring the provision of CHW services complies with all applicable requirements as described herein
- Maintain evidence of CHWs completing continuing education requirements in case of audit and may provide and/or require additional training
- Ensure CHWs meet the qualifications listed in ***the APL 22-016 (Revised) Community Health Worker Services Benefit*** and oversee the services delivered to Medi-Cal members
- Must provide direct or indirect oversight to CHWs
    - Direct includes, but is not limited to, guiding CHWs in providing services, participating in the development of a Plan of Care, and following up on the progression of their services
    - Indirect includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements
- MCP Network Providers, including Supervising Providers, are required to enroll as Medi-Cal providers if there is a state-level enrollment pathway
    - Those with a state-level Medi-Cal enrollment pathway, must follow the standard process for enrolling through the DHCS Provider Enrollment Division
- Some may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program
    - Providers must be vetted by the MCP to participate as Supervising Providers
- Credentialing requirements ***(APL 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment)*** only apply to providers with a state-level pathway for Medi-Cal enrollment

Supervising Providers without a state-level pathway are not required to meet the screening/enrollment and credentialing requirements to become "in-network."

Eligibility Criteria for services

Services are considered medically necessary for CenCal Health members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers to meeting their health or health-related social needs, and/or who would benefit from preventive services.
Recommending provider shall determine whether a member meets the medical necessity criteria for CHW services based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed
- Presence of medical indicators of rising risk of chronic disease (for example, elevated blood pressure, elevated blood glucose levels, etc., that indicate risk but do not yet warrant diagnosis of a chronic condition)
- Positive Adverse Childhood Events (ACEs) screening
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse
- Results of a social drivers of health screening indicating unmet health-related social needs, such as housing or food insecurity
- One or more visits to a hospital emergency department within the previous six months
- One or more hospital inpatient stays, including stays at a psychiatric facility within the previous six months, or being at risk of institutionalization
- One or more stays at a detox facility within the previous year
- Two or more missed medical appointments within the previous six months
- Beneficiary expressed a need for support in health system navigation or resource coordination services

Authorization Requirements

CHW services require a written recommendation from a licensed practitioner. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a Network Provider in CenCal Health. Services are recognized in 30-minute units, and the first 12 units (6 hours) are auto-approved. For requests in excess of the initial 12 units, a Treatment Authorization Request (TAR) and 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.

Claims & Billing

CHW services must be reimbursed through a Supervising Provider in accordance with its provider contract, unless reimbursed directly through CenCal Health if the CHW is a Medi-Cal enrolled provider.

Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual
Must not double bill for duplicative CHW services for the same member for the same time reimbursed through other benefits such as ECM, inclusive of the services within the CHW benefit
CPT codes may be used for all services by the Supervising Provider when submitting claims, including:

CenCal HEALTH
Local. Quality. Healthcare.

- Education and training for member self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)

Maximum frequency: 4 units (2 hours) daily per beneficiary

- Additional units per day may be provided with an approved Treatment Authorization Request (TAR) for medical necessity
    - TARs may be submitted after the service was provided

Charges for the direct benefit services of the member must be billed under the member's Medi-Cal ID.

CPT Code	Session Length	Patient Numbers
98960	30 Minutes	1
98961	30 Minutes	2 - 4
98962	30 Minutes	5 - 8

In addition, the following are new allowable modifiers that may be used with these CPT codes:

Modifiers	Description
U2	Used to denote services rendered by Community Health workers
U3	Used to denote services rendered by Asthma Preventive Service providers

Reference Link:
DHCS ALL Plan Letter (APL) 22-16:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-016.pdf

Onboarding Packet
/www.cencalhealth.org/providers/join-our-network/credentialing-applications-and-forms/