



Pharmacy Procedure Manual

Revised January 2008

MedImpact
Pharmacy Benefit Manager

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INTRODUCTION

CenCal Health, a health insuring organization, administers various publicly-funded health care plans serving the residents of Santa Barbara and San Luis Obispo Counties. The following are the current and future programs CenCal Health administers:

- **Santa Barbara Health Initiative (SBHI)**, the first case managed Medi-Cal program in the State of California, was initiated in 1983 for Santa Barbara County's Medi-Cal patients. Our program has been widely viewed as a model for other counties and states. Currently there are over 54,000 eligible members of varying ages, categories of aid, and medical conditions in Santa Barbara County. Our Primary Care Physicians (PCPs) case manage those members who have chosen or been assigned to them.
- **San Luis Obispo Health Initiative (SLOHI)**, *effective March 1, 2008*, is CenCal Health's program for Medi-Cal recipients in San Luis Obispo County. There are approximately 27,000 eligible members who will be transitioned from the State of California (DHS/EDS) to the administration of their healthcare by CenCal Health.
- **Prenatal PLUS 2 (PP2)** is CenCal Health's version of the statewide "Access for Infants and Mothers" (AIM) program. This program, funded by tobacco taxes and subscriber contributions, offers low-cost insurance to pregnant women and their newborns up to age two.
- **Healthy Families Program (HFP) CenCal Health** is one of several Healthy Families plans in both Santa Barbara and San Luis Obispo Counties available to low-income children under 19 years of age. Healthy Families is California's version of the Federal Children's Health Initiative.
- **In Home Supportive Services (IHSS)** are services provided with State funding to homebound persons in order to assist with activities of daily living. IHSS is not a Medi-Cal benefit. IHSS workers (also known as "Providers") are employed by a Public Authority established and managed by the County Department of Social Services.
- **Healthy Kids Program (HK)** is a new program established through CenCal Health. HK provides healthcare access to children of low-income parents who do not qualify for Medi-Cal or Healthy Families. HK is currently available in both Santa Barbara and San Luis Obispo Counties.

CenCal Health holds contracts with over 100 PCPs and nearly 1,000 group and individual providers of all types. Most of our programs' populations select a PCP to act as their case manager. Our PCPs may refer to other providers as appropriate and within the scope of the program.

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

This manual shall serve to:

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

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

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

This CenCal Health Pharmacy Manual has been prepared to provide you with information that should reduce the need to contact CenCal Health or MedImpact for clarification and should minimize delays with the prescription filling process; however, CenCal Health realizes that improvements can always be made and that excellence can only be achieved through continuous quality improvement. As such, CenCal Health welcomes any suggestions related to this manual. Communication related to suggestions for improvement should be directed to the CenCal Health Provider Services Department at (800) 421-2560 or (805) 685-9525, extension 1676.

This manual is not intended to detail how pharmacy should be practiced or how prescriptions should be filled.

1. GENERAL INFORMATION

Participating Pharmacy Network

CenCal Health maintains an “any willing” pharmacy provider network. All participating pharmacies that provide pharmacy services for eligible members of CenCal Health are contracted with MedImpact:

MedImpact Healthcare Systems, Inc.
Operations Dept., Attn: Claims
10680 Treena St., 15th Floor
San Diego, CA 92131

Contracted pharmacy providers located in CenCal Health’s service area are referred to as “in-network” pharmacy providers; “in-network” pharmacy providers are those having their operations in Santa Barbara and/or San Luis Obispo Counties. All other CenCal Health pharmacy providers are referred to as the “broad network” pharmacy providers. All CenCal Health members are provided with an updated list of “in-network” pharmacy providers at the time of their enrollment.

Pharmacy Reimbursement

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

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

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

Pharmacy & Therapeutics (P&T) Committee

The Pharmacy & Therapeutics (P&T) Committee meets quarterly, or as needed, to provide proper guidance for the development, implementation, and maintenance of the CenCal Health Drug Formulary. The P&T Committee is responsible for making recommendations to CenCal Health regarding the content of the CenCal Health Drug Formulary and other clinical matters regarding the CenCal Health drug benefit. The Committee's membership is comprised of the CenCal Health Medical Director, the CenCal Health Director of Pharmacy Services, network physicians, network pharmacists, and other health care professionals from the community. Community practitioners interested in becoming a P&T Committee member may contact CenCal Health's Pharmacy Services Department at (800) 421-2560 or (805) 685-9525, extension 1639.

Drug Formulary

The CenCal Health Drug Formulary is a listing of medications approved and covered by CenCal Health. This is a "living" document and will change according to the latest developments in clinical, evidence-based literature. CenCal Health's Drug Formulary is available on CenCal Health's website at www.cencalhealth.org. CenCal Health has also made the Formulary available at ePocrates™ which can be downloaded to a desktop or a hand-held PDA device.

Scope of Prescription Drug Benefit Coverage

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

Member Co-payments

- **Santa Barbara Health Initiative (SBHI)**
Pharmacy providers may attempt to collect a Medi-Cal co-payment from a Santa Barbara Health Initiative (SBHI) Medi-Cal member in most situations. A member can pay or obligate to pay the Medi-Cal co-payment amount at the time of service. The collection of Medi-Cal co-payments by the pharmacy is optional. A provider of service, under law, cannot deny services to an individual because of the person's inability to pay. If a pharmacy is unsuccessful in their attempts to collect the Medi-Cal co-payment, the pharmacy may not inform the member that their prescriptions are not covered. It is misrepresentation of the CenCal Health drug benefit by pharmacy providers to attempt to collect a payment

from an SBHI member and inform them that their prescriptions are not covered. CenCal Health is concerned that such responses misrepresent the scope of CenCal Health drug coverage and result in members not receiving needed medications. Those pharmacies identified as misrepresenting the CenCal Health scope of coverage will be subject to corrective action by CenCal Health.

Pharmacy providers may NOT collect Medi-Cal co-payments from SBHI members for the following:

- Services for which the program's payment is \$10.00 or less
 - Member has other health coverage, which pays an amount equal to or greater than the prescription reimbursement amount
 - The Medi-Cal copayment amount exceeds the lesser of the amount a member would be required to pay if they did not have other coverage or the difference between such third party and the CenCal Health payment amount
 - Persons age 18 or under
 - Any child on TANF-Foster Care
 - Persons who are inpatients of a health care facility (hospital, skilled nursing facility, or intermediate care facility)
 - Any hospice patient
 - Any woman during pregnancy and the postpartum period (through the end of the month in which the 60-day period following termination of pregnancy ends)
 - Family planning services and supplies.
- **Healthy Families (HFP)**
Healthy Families members are required to make a \$5.00 co-payment for prescription drugs, with the exception of contraceptives, at the time services are received. Over-the-counter drugs are NOT a benefit of Healthy Families. If a family's total co-payments to one provider exceed \$25.00 in one month, it is the provider's responsibility to offer an extended payment plan for any additional co-payments during that month. Members who qualify to participate for the cost-sharing waiver for American Indian/Alaskan Natives are NOT required to pay co-payments.
 - ***Prenatal PLUS 2 (PP2)***
There are no co-payments for ***Prenatal PLUS 2*** members.
 - **Healthy Kids (HK)**
Healthy Kids members are required to make a \$5.00 co-payment for prescription drugs, with the exception of contraceptives, at the time services are received. Over-the-counter drugs are NOT a benefit of Healthy Kids. If a family's total co-payments to one provider exceed \$25.00 in one month, it is the provider's responsibility to offer an extended

payment plan for any additional co-payments during that month. Members who qualify to participate for the cost-sharing waiver for American Indian/Alaskan Natives are NOT required to pay co-payments.

- **In-Home Supportive Services (IHSS)**

In-Home Supportive Services members are required to make the following co-payments for 30 day or one (1) month supply based on package size, one cycle of tobacco cessation drugs, as well as formula and special food products for the treatment of phenylketonuria (PKU): a \$15.00 co-payment for generic formulary drugs, a \$25.00 co-payment for brand name formulary drugs, and a \$50.00 co-payment for non-formulary drugs. In addition, the co-payments for a 90 day supply of maintenance drugs by Mail Order are \$20.00 co-payment for generic formulary drugs, a \$50.00 co-payment for brand name formulary drugs, and a \$150.00 co-payment for non-formulary drugs. There are no co-payments in the following circumstances: inpatient drugs to members in an inpatient setting, drugs administered in the doctor's office, or drugs administered in an outpatient facility setting during the member's stay at the facility.

USEFUL TELEPHONE AND FACSIMILE NUMBERS

Contact	Subject	Number
MedImpact Help Desk Hours: 24 hours a day, seven days a week	- Pharmacy Provider Support / Help Desk - On-Line Claims Assistance	(800) 788-2949
CenCal Health Hours: M-F: 8:00am - 5:00 pm Except Holidays	- General Information <i>The extensions below shall apply to these numbers unless otherwise stated</i>	(800) 421-2560 (805) 685-9525
CenCal Health Claims Dept.	- Claims / Billing Inquiries (for paper claims billed directly to CenCal Health only) - Eligibility Inquiries for on-line processing	Ext. 1053 or 1061
CenCal Health Pharmacy Dept.	- Drug Formulary - MRF Process	Ext. 2229
CenCal Health Provider Services Dept.	- General Provider Inquiries - Supplies (MRFs)	Ext. 1676 Ext. 1672
CenCal Health Recoveries / Finance Dept.	- Health Insurance Premium Payment (HIPP) Program - Retro-Medicare / Recovery Program - OHC Recovery Program	Ext. 1071 or 1066 Ext. 1071 Ext. 1073 or 1068
CenCal Health Member Services	- Member Related Assistance	(877) 814-1861
State Medi-Cal: EDS (Electronic Data Systems)	- State Medi-Cal Help Desk	(800) 541-5555
State AEVS (Automated Eligibility Verification System)	- Eligibility Verification - Share of Cost Transactions	(800) 456-2387
Medical Request Form (MRF) Fax Submission	- Fax Submission of MRF	(805) 685-7781 fax

2. MEMBER ELIGIBILITY

CenCal Health receives member eligibility for its members, and it is then forwarded to MedImpact for inclusion into their on-line eligibility system.

Eligibility Verification

Each CenCal Health member should present either a SBHI (Medi-Cal), PP2, HFP, HK, or IHSS Healthcare Identification Card at the time they have a prescription filled. (Samples included in this section.) The Identification Card contains the member's name, birth date, and identification number. The identification number (ID) is the member number to be used when submitting claims to MedImpact. In the unlikely incidence that a prescription claim is rejected by MedImpact for "Non-Matched Cardholder ID," eligibility may be verified by any one of the following procedures:

- via the CenCal Health website www.cencalhealth.org. To receive a password, e-mail the webmaster@cencalhealth.org
- by calling the State Automated Eligibility Verification System (AEVS) at (800) 456-2387
- by calling the CenCal Health Member Services Department at (800) 421-2560 or (805) 685-9525, extension 1001, Monday through Friday, 8:00 a.m. to 5:00 p.m.

If a member's eligibility needs to be updated on an urgent basis, you may call CenCal Health at (800) 421-2560 or (805) 685-9525, extension 1053 or 1061, Monday through Friday, 8:00 a.m. to 5:00 p.m., and request the eligibility file to be updated as soon as possible.

During the interim while the member's eligibility status is being researched, pharmacies should exercise appropriate clinical judgment when determining whether to dispense medication(s) pending eligibility verification.

Retroactive Eligibility

Some CenCal Health members may become retroactively eligible for CenCal Health after the month in which services were rendered. To verify retroactive eligibility, use any one of the eligibility verification methods above or call the CenCal Health Claims Department at extension 1053 or 1061. Please refer to the Claims Submission section of this manual for timeliness billing of retroactive claims.

Newborns

SBHI newborns are eligible for pharmacy benefits the month of birth and the ensuing month under the mother's eligibility and ID number. If information on the newborn is not found in CenCal Health's eligibility system, you may call CenCal Health at (800) 421-2560 or (805) 685-9525, extension 1053 or 1061, Monday through Friday, 8:00 a.m. to 5:00 p.m. and request that newborn member be entered into our system. PP2, HF and HK newborns will have their own identification number for claims processing. Please refer to the Claims Submission section of this manual for billing instructions. The IHSS Healthcare plan does not provide newborn coverage.

Share of Cost (SOC)

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

Restricted Services

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

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

Providers may request that a CenCal Health member be reviewed for potential restricted status by contacting the CenCal Health Pharmacy Services Department at (800) 421-2560 or (805) 685-9525, extension 1639.

California Children Services (CCS)

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

SBHI, HF and HK members may also be CCS eligible. Services for those members are paid by CenCal Health. Prescription claims are to be submitted to MedImpact for processing. The CCS program will authorize services related to the eligible condition. Prescribers are to submit MRFs to CenCal Health who will route for approval.

Genetically Handicapped Persons Program (GHPP)

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

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

All prescription claims for CenCal Health members with GHPP eligibility are paid for by CenCal Health and should be submitted to MedImpact. Referrals and questions may be directed to the GHPP program at (916) 327-0470 or (800) 639-0597.

Other Health Coverage (OHC)

Other Health Coverage (OHC) is any private health insurance plan or policy under which the recipient is entitled to receive health care services. OHC includes benefits through commercial insurance companies, prepaid health plans, Health Maintenance Organizations (HMOs), as well as any organization that administers a health plan for professional associations, unions, fraternal groups, and employer-employee benefit plans, including self-insured and self-funded plans.

Eligibility under Medicare is not considered OHC; however, Medicare supplemental policies are considered OHC. Please refer to the Coordination of Benefits (COB) section of this manual for instructions on billing for members with OHC and Medicare covered drugs and supplies.

CenCal Health's current health plans are always the payer of last resort, with the exception of the IHSS Healthcare plan which is primary. If a member has both Medi-Cal and Healthy Families, Healthy Families is also primary. All pharmacy providers are required to bill OHC and/or Medicare before billing CenCal Health. Please refer to the Coordination of Benefits (COB) section of this manual for billing instructions of secondary coverage

Medicare

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

Effective January 1, 2006, dual-eligible members (those individuals who have both Medicare and Medi-Cal coverage), will have their Medi-Cal covered drugs provided through the new Medicare Part D Program and the Prescription Drug Plan (PDP). After January 1, 2006, CenCal Health will no longer be responsible for the outpatient drug benefit of dual-eligible members as mandated by the federal government through this new drug reform. CenCal Health will, however, continue to cover a minimal amount of therapeutic drugs. Those drugs are identified through CenCal Health's formulary located on our website at www.cencalhealth.org. All communications regarding the PDP's policies, formulary, and prior authorizations need to be directed to the PDP itself or to Medicare via 1-800-Medicare.

In the event that eligibility shows a member as having Medicare Part D coverage but the Prescription Drug Plan carrier does not yet appear in the eligibility system, pharmacy providers can bill the CMS WellPoint/Anthem POS (Part D Facilitated Enrollment) system.

CenCal Health Member ID Cards

All members under CenCal Health programs will have the following version of their member identification cards. The Group name will identify which CenCal Health program the member has benefits.



Santa Barbara Health Initiative (SBHI)

Group: 110 SB HEALTH INITIATIVE
Pharmacy BIN: 003585
Carrier or Processor Control #: 56010

San Luis Obispo Health Initiative (SLOHI)

Group: 120 SL HEALTH INITIATIVE
Pharmacy BIN: 003585
Carrier or Processor Control #: 56420

Healthy Families Program (HFP)

Pharmacy BIN: 003585

HFP Santa Barbara

Group: 210 SB HEALTHY FAMILIES
Carrier or Processor Control #: 56030

HFP San Luis Obispo

Group: 211 SL HEALTHY FAMILIES
Carrier or Processor Control #: 56148

Healthy Kids (HK)

Pharmacy BIN: 003585




HK Santa Barbara

Group: 231 SB HEALTHY KIDS
Carrier or Processor Control #: 56121

HK San Luis Obispo

Group: 232 SL HEALTHY KIDS
Carrier or Processor Control #: 56135

CenCal Health Member ID Cards (con't.)

		110 Castilian Dr. • Goleta, CA 93117 Toll Free 1 (877) 814-1861 CenCalHealth.org	
Group		D.O.B.	
Member Name		Member ID Number	
Primary Care Provider		PCP Phone No.	
			

Prenatal Plus 2 (PP2)

Group: 220 SB PRENATAL PLUS 2
Pharmacy BIN: 003585
Carrier or Processor Control #: 56020

In-Home Supportive Services (IHSS)

Group: 310 SB IHSS PLAN
Pharmacy BIN: 003585
Carrier or Processor Control #: 56055

3. COVERED SERVICES

This section of the CenCal Health Pharmacy Manual contains an overview of prescription benefits provided to CenCal Health members, as well as specific guidelines for the pharmacy provider when providing prescription services to CenCal Health members. Information regarding claim submission through MedImpact's on-line prescription claims processing system or for claims billed directly to CenCal Health is provided in the Claims Submission section of this manual. Additional information regarding the Medical Request Form (MRF) can be found in the section titled Medical Request Form (MRF) Process.

Prescription Drugs

CenCal Health's prescription drug formulary contains selected Federal Legend Drugs from all the major therapeutic drug classes. The drugs are listed in the drug formulary by both the generic and/or brand name. The Formulary can be found at www.cencalhealth.org.

Dual Eligible Members Prescription Drug Coverage

The provision of the drug benefit for our dual-eligible members (those individuals who have both Medicare and Medi-Cal coverage) has shifted from CenCal Health to a Medicare D provider. If the member has Medicare Part D coverage, the pharmacy must submit claims for Medicare-covered drugs/supplies to the Medicare carrier as the primary insurance. Some medications, i.e., benzodiazepines, barbiturates, over the counter (OTC), weight loss or gain, cough and cold preps, as well as some diabetic supplies (lancets, test strips), will still be provided by CenCal Health.

Injectable Drugs

Some non-compounded injectable drugs are covered and billed on-line to MedImpact. Other injectables are covered under the medical benefit and billed to CenCal Health. Covered injectable drugs are listed in the Formulary found at www.cencalhealth.org.

Compounded IV Infusions

Home Infusion Therapy is a covered benefit for CenCal Health members. Claims for compounded IV infusion drugs do not require a MRF if all the drugs are listed in the Formulary. All drugs compounded for IV infusion and related administration supplies must be paper billed directly to the CenCal Health Claims Department.

Compounded Non-Parenteral Drugs

Compounded prescriptions for non-parenteral use require a MRF. The MRF must be completed and faxed to CenCal Health at (805) 685-7781. See the Claims Submission section for billing instructions.

Specialty Pharmacy Program

Effective July 1, 2007, CenCal Health implemented a new Specialty Pharmacy Program. This program covers injectable medications used to treat chronic diseases. The following Therapeutic Classes are covered under CenCal Health's Specialty Pharmacy Program:

- Multiple Sclerosis
- Rheumatoid Arthritis
- Hepatitis C
- RSV (Synagis)
- Growth Hormone Deficiency
- Psoriasis
- Antisera
- Hemophilia
- Oral Oncolytics (effective June 1, 2008)

McKesson Specialty is the vendor for our Specialty Pharmacy Program and thus all prescriptions for the above categories should be processed through them. If you have any questions regarding this new program under CenCal Health's pharmacy benefit, please contact the Pharmacy Department at extension 1639 or contact McKesson Specialty Pharmacy Services directly at (888) 456-7274.

Over-the-Counter (OTC) Drugs

Selected over-the-counter (OTC) drugs are a part of the SBHI and PP2 benefit if prescribed by a physician. Providers cannot separately bill for any OTC drugs for members residing in a nursing facility as OTC drugs are included in the per-diem rate. OTC drugs are listed in the Formulary which is available online at www.cencalhealth.org.

Medical Supplies

Medical supplies, including diabetic supplies, ostomy supplies, incontinence supplies, and disposable gloves are covered benefits for selected CenCal Health programs. Covered items for SBHI/SLOHI can be found on the Medical Supplies List in your Medi-Cal Pharmacy Provider Manual or on the Medi-Cal website www.medi-cal.ca.gov. See Prescription Limitations below. For further information contact CenCal Health at (805) 685-9525 ext. 1061.

Nutritional Products (Oral / Enteral)

Nutritional products for oral and enteral administration are a covered benefit for selected CenCal Health programs with an approved MRF.

Prescription Limitations

- **SBHI Prescription Benefit – Polypharmacy**

In our continuing efforts to improve patient safety and quality of care, CenCal Health has implemented a Polypharmacy Management Quality Initiative for Santa Barbara Health Initiative (SBHI) members. The scope of pharmacy benefits for SBHI members will include a maximum benefit of ten (10) prescriptions per calendar month. The following disease states and categories are exempt from this restriction:

- Nursing Facility Patients
- Newborns using Mother's Identification Number
- Antibiotic Medications
- Medications for Family Planning such as oral contraceptives
- Medications for Treatment of Acquired Immune Deficiency Syndrome or AIDS Related Conditions
- Medications for Cancer Treatment
- Medications for Diabetes Treatment
- Medications for Transplant Patients

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

- If the member does not meet any of the above criteria and their physician has consolidated the member's profile, the physician may request a **Pharmacy Authorization Form (PAF)**. This form, to be completed by physicians only, is for members being treated for specific disease states, not including the above, and who will continue to require more than ten (10) prescriptions each month. Each request will be reviewed by a Licensed Clinical Professional. Please fax PAF requests to (805) 685-5191. If the member exceeds the monthly prescription limit and does not meet any of the above criteria, a prior authorization (MRF) is required. Please fax all MRF requests to (805) 685-7781. The PAF and MRF are available to download at www.cencalhealth.org.

- **Mandatory Generic Substitution**

CenCal Health generally mandates generic substitution when an AB rated equivalent generic product is available. In most programs, if a prescriber wants a brand name drug and issues a “do not substitute” order, he/she must submit a MRF for approval.

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

- **Code 1 Restricted Drugs**

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

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

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

- **Days Supply Limits**

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

- **Medical Supplies Limits for SBHI**

Diabetic Supplies: blood glucose strips and lancets are limited to a maximum of 100 per 30 days.



CenCal Health Use Only

Date

(Please Print)

Request for Member Exemption from the Monthly Prescription Limit

Only submit this form for members receiving 10 or more chronic, necessary medications. Use extra copies of this same form if there are more diseases or therapies than will fit on one page.

The therapies for given conditions will receive a consultation by a Doctor of Pharmacy to identify opportunities for regimen simplification based on current evidence-based medicine and nationally recognized clinical practice guidelines.

Submission of this form does not guarantee that the member will be exempt from the monthly medication limit. Feedback will be given to the **prescriber** submitting this form. **If a member is exempt from the monthly prescription limit, s/he will still require a MRF for medications not on the CenCal Health formulary.**

MEMBER INFORMATION			
Member Name (Last, First)		Date of Birth	Member ID Number
Member Address (Street, City, State, Zip)			Phone
PHYSICIAN INFORMATION			
Name (Last, First)		Specialty	DEA #
Address (Street, City, State, Zip)			
Phone		FAX	
ONLY LIST CHRONIC MEDICATIONS			
1. Diagnosis		Established Length of Therapy	
Corresponding Medication(s)			
2. Diagnosis		Established Length of Therapy	
Corresponding Medication(s)			
3. Diagnosis		Established Length of Therapy	
Corresponding Medication(s)			
TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.			
Signature of Physician or Provider		Title	Date
X			
CenCal Health Staff Use Only			
Provider, your request is: <input type="checkbox"/> Approved as requested <input type="checkbox"/> Approved as modified <input type="checkbox"/> Denied <input type="checkbox"/> Deferred			Reviewer's Signature
I.D. #	Date	Comments/Explanation	
Approved Units	NDC#/PMI#/GPI#	Quantity	Specific Services Requested
Authorization is valid for services provided from _____ Date _____ to _____ Date _____		110 Castilian Drive • Goleta, CA 93117-3028 (800) 421-2560, Ext. 2229 • (805) 685-9525, Ext. 2229 www.cencalhealth.org	

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

4. FORMULARY OVERVIEW

The CenCal Health Formulary is updated on a continuing basis. The CenCal Health Pharmacy & Therapeutics (P&T) Committee meets quarterly and is responsible for reviewing additions, changes, and deletions to the Formulary. The P&T Committee updates and revises the Formulary based on sound clinical evidence, efficacy, safety and pharmacoeconomic considerations. Recommended formulary modifications may be requested by CenCal Health prescribers, pharmacists, or CenCal Health staff. All suggested formulary modifications should be directed to CenCal Health.

The CenCal Health Formulary is available at CenCal Health's website at www.cencalhealth.org. CenCal Health has also made the Formulary available on ePocrates that can be downloaded to a desktop computer or hand-held PDA device.

5. PHARMACY UPDATES

Upon occasion, there may be a need to update the policies and processes to CenCal Health's pharmacy benefit through a separate communication usually via facsimile. Please insert copies of MedImpact and CenCal Health's Pharmacy Updates in this section.

6. MEDICAL REQUEST FORM (MRF) PROCESS

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

Prescriptions for the following require a MRF:

- All non-formulary medications
- Brand name drugs when an equivalent generic is available except for those drugs listed as exemptions
- Drugs not meeting the Code 1 restriction or Step Therapy criteria
- Drugs exceeding the member age, dosing limit, quantity or duration of treatment dispensing limits.

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

Medical Request Forms (MRFs)

CenCal Health utilizes the Medical Request Form (MRF). A sample MRF has been included in this section. Providers may obtain MRFs by contacting CenCal Health at (800) 421-2560 or (805) 685-9525, extension 1672 or by accessing the restricted area under the For Providers section of our website at www.cencalhealth.org. Please contact the Webmaster at webmaster@cencalhealth.org for a password to access this area of the website.

Providers who have questions regarding the MRF process may contact CenCal Health at (800) 421-2560 or (805) 685-9525, extension 2229.

MRF Submission

A MRF must be completed by the prescriber and faxed to CenCal Health at (805) 685-7781. **Please submit only one drug per MRF.** Fill the form out in its entirety, starting with the Exceeded 10 RX Monthly Limit and Today's Date boxes in the top right hand corner.

- Required member information includes: member's name, ID#, birth date, address and phone number, member Medicare eligibility and status.
- Required prescriber information includes: prescriber name, specialty, phone and fax numbers, DEA#, and address.

Under the heading of Requested Medication Information include the drug name and strength, dosing schedule, diagnosis, and estimated length of drug

therapy, ICD-9 Code(s) as well as fill in the retroactive request box if appropriate. If the request is retroactive, include the date and the reason for the retroactive request. In the following sections, explain why this drug is being requested and include previous medications tried; please be specific and thorough. Directly below is the space for the Prescribers signature; include the date in the box indicated after the signature. If a prescriber would like to have the pharmacy notified, write the pharmacy name and fax number in the bottom right hand corner of the Previous Medications Tried box.

Timely Submission of MRFs

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

Retroactive MRFs

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

- When certification of the member's eligibility by the appropriate entity was delayed
- When other coverage (e.g. Medicare or other health insurance) denied payment of a claim for services
- When a member did not identify himself/herself to the provider as an CenCal Health member by deliberate concealment or because of physical or mental incapacity to identify himself/herself.

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

Provider Notification of MRF Action

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

Approved MRFs

The approved MRF is entered into the MedImpact system and faxed back to the **provider**. If this is the prescriber, please notify either the patient or the pharmacy filling the prescription so that the member can get his or her medication in a timely manner. The approved MRF is entered directly into the member's prescription file, and the billing provider is NOT required to enter the MRF Control Sequence Number when submitting the claim to MedImpact.

Deferred MRFs

Incomplete MRFs, or ones that require additional information, will be deferred back to the submitter by MedImpact. If the submitter does not respond to the request for additional information within twenty-eight (28) calendar days for Medi-

Cal plans or thirty (30) calendar days for non-Medi-Cal plans (HFP, HK, PP2, IHSS), the MRF will be denied.

Denied MRFs

Written notification of a denied MRF that lacks medical justification for the intended use of the drug or a MRF deferred for more than thirty (30) calendar days will be sent to the member within two (2) business days and the prescribing physician within twenty-four (24) hours from the time of the decision. The Primary Care Provider (PCP), if different from the prescriber, will also be sent written notification of the denied MRF within twenty-four (24) hours from the time of the decision. If a pharmacy has been involved in the MRF process, the pharmacy will also be sent written notification of the denied MRF within twenty-four (24) hours from the time of the decision. The denied MRF will include the reason for the denial and information about the appeals process.

Emergency After Hours Authorizations

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

MRF Completion

The MRF completion procedure allows only one drug per MRF.

Providers who have questions regarding the MRF process may contact CenCal Health at (800) 421-2560 or (805) 685-9525, extension 2229.

Appeal of a Medical Request Form (MRF)

Providers may appeal denied or modified MRFs by submitting the following documentation within thirty (30) calendar days from the date of the original decision:

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

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

The appeal decision shall be reviewed by the Medical Director or a qualified licensed Medical Director Designee who may reverse the denial. The provider

will receive a written response within thirty (30) calendar days of receipt regarding the final determination of the appeal.

If the service has not been provided, the provider may inform the member of his or her right to file an appeal by contacting CenCal Health's Member Services Department:

By writing to:
CenCal Health
Member Services Department
110 Castilian Drive
Goleta, CA 93117

or


By calling 8:00 a.m. to 5:00 p.m. - Monday through Friday:
1-877-814-1861 (Toll-Free)
805-685-4131 TDHI (Telecommunications Device for the Hearing Impaired)

CenCal Health offers members the right to an independent, third party review whenever the member is appealing an adverse determination that is based on medical necessity. CenCal Health may elect to bypass the internal review and proceed to an independent review. The decision of the external review body is binding on CenCal Health.

Expedited Appeals

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

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

For additional information about MRF appeals, call (805) 685-9525, extension 1640. 



CenCal Health Use Only

(Please Print)

Exceeded 10 Rx Monthly Limit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Today's Date
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Member ID	Member Name	ID #	Birthdate
	Member Address	Member Phone No.	
	PCP Name	Is patient Medi-Care eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Status <input type="checkbox"/> Home <input type="checkbox"/> Board & Care <input type="checkbox"/> NF/ICF <input type="checkbox"/> Acute Hospital

Prescriber Name	Specialty	Phone No.	FAX No.
DEA #	Medi-Cal No.	NPI #	
Address		e-mail address	

REQUESTED MEDICATION INFORMATION

Drug Name/Strength (mg)/Dosing schedule	Estimated length of drug therapy (1 month, etc./why?)
Diagnosis	ICD-9 Code(s)
Request is retroactive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:

Please explain why you are requesting the use of this medication:

Previous Medications Tried:	
<u>Medication / Strength</u>	<u>Outcome of Medication Tried</u>

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

Signature of Physician or Provider X	Title	Date
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CenCal Health Staff Use Only

Provider, your request is: <input type="checkbox"/> Approved as requested <input type="checkbox"/> Approved as modified <input type="checkbox"/> Denied <input type="checkbox"/> Deferred			Reviewer's Signature X
I.D. #	Date	Comments/Explanation	

Approved Units	NDC#/PMI#/GPI#	Quantity	Specific Services Requested

Authorization is valid for services provided from _____ Date to _____ Date	110 Castilian Drive Goleta, CA 93117-3028 (800) 421-2560, Ext. 2229 (805) 685-9525, Ext. 2229 www.cencalhealth.org
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NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

7. CLAIMS SUBMISSION

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

Any routine prescription drug claims submitted directly to CenCal Health will be returned to the provider for submission to MedImpact. Compound drugs and medical supplies without NDC numbers are to be submitted to CenCal Health using the 30-1CZ claim form.

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

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

National Provider Identifiers

After May 23, 2007, all healthcare providers and plans will be required to use and accept only National Provider Identifiers (NPIs) in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting standard transactions with multiple health plans. This effective date is not based upon date of service (DOS). For pharmacy providers, the NPI will replace the NCPDP (NABP) number in all transactions.

MedImpact will begin accepting and using the NPI for pharmacies on and after May 23, 2007; however, pharmacies must register their NPI with the National Council for Prescription Drug Programs, Inc. (NCPDP) for MedImpact to recognize them. MedImpact validates the NPI based upon the pharmacy's NPI registration with the NCPDP organization. In addition, the NPI submitted must be uniquely associated with only one NCPDP.

If you have any questions regarding the conversion to NPI, please contact CenCal Health's Provider Services Department at extension 1676.

Electronic Claims Submission (ECS)

MedImpact's prescription claims processing is accomplished in a real-time point-of-sale process. As of May 23, 2007, MedImpact will no longer accept the NCPDP version 3.x because that version cannot support the NPI length of ten

(10) digits. MedImpact will only accept NCPDP 5.1 claims after May 23, 2007.
The BIN Number or “Electronic Address” for MedImpact is 003585.

Member information required for submitting on-line claims is as follows:

1. First and last name
2. Date of birth (DOB)
3. 9-digit ID number for SBHI, HFP and HK; 11-digit ID number for PP2 and IHSS
4. Relationship to cardholder (“01” for self, “03” for newborn and “04” for the twin until ID number obtained)
5. Gender

On-Line Drug Utilization Review (DUR)

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

Claim Form (30-1CZ) Billing

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

Timeliness of Submitted Claims

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

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

Dispense as Written (DAW)

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

- Lanoxin
- Dilantin
- Premarin
- Synthroid

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

Rejected Claims

Frequently rejected claims are due to:

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

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

Return to Stock / Claim Reversal

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

Refill Too Soon

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

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

Refill Too Soon - Nursing Facility

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

Lost, Stolen, or Spilled Medications

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

Vacation Supply

MedImpact may approve a one time override per medication within a one-year time frame for a vacation supply of up to sixty (60) days.

SBHI Newborns

SBHI newborns are eligible for pharmacy benefits the month of birth and the ensuing month under the mother’s eligibility. Claims submissions for newborns should be under the mother’s nine-digit ID number (social security number) using the newborn’s name and date of birth and a cardholder relationship of “03.” Claims submission after this time frame will require the newborn to be eligible under his/her own ID number. Please contact (805) 685-9525 extension 1053 or 1053 or 1061 for this to be updated in the MedImpact system.

Prescriber Identification Number

All prescriptions submitted to CenCal Health must include the prescriber's identification number. CenCal Health will reject claims submitted without a valid identification number. The physician identification number to be submitted shall be the NCPDP defined physician identification number when it becomes available. Until the NCPDP supplied number becomes available, the prescriber's NPI or DEA number will continue to be utilized. Prescriptions written by a Physician Assistant (PA), Nurse Midwife (NM), and Nurse Practitioner (NP) must meet State law and be submitted using the supervising physician's NPI or DEA number.

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

Code 1 Restricted Drugs

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

Nutritional Products (Oral/Enteral)

A Medical Request Form (MRF) is required for all nutritional products except covered vitamins and minerals to be used on an outpatient basis. **Claims submission to MedImpact for nutritional products require the quantity submitted to be in milliliters (mls) or grams (gms), not number of boxes, cans or bottles.** Claims for administration supplies for enteral feedings are to be submitted on a 30-1CZ claim form to the CenCal Health Claims Department. Products for members residing in an acute care hospital or Long Term Care (LTC) facility are included in the per diem rate paid to the facility.

Medical Supplies

Claims submissions for medical supply items not listed in the Medi-Cal Pharmacy Provider Manual require an approved Treatment Authorization Request (TAR) for payment. Claims for formulary medical supplies approved by a TAR (excluding incontinence supplies, disposable gloves, and ostomy supplies) with a National Drug Code (NDC) number must be submitted to CenCal Health. Items without an NDC number, all incontinence supplies, disposable gloves, and ostomy

supplies must be submitted directly on a 30-1CZ claim form to the CenCal Health Claims Department.

Providers with questions regarding claims submitted to the CenCal Health Claims Department may contact that department directly at (800) 421-2560 or (805) 685-9525, extension 1053 or 1061.

CCS Claims Submission Procedure

Most pharmacy claims for these members should be billed on-line to MedImpact.

8. COORDINATION OF BENEFITS (COB)

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

MedImpact's Point of Sale (POS) network is equipped to accept and adjudicate claims where there is a denial and/or partial payment from the other health coverage, and providers are encouraged to bill online for these services. Providers may not refuse service to CenCal Health members who have other insurance coverage in addition to CenCal Health Medi-Cal, nor may they refuse service because of the requirement to hardcopy bill. Pharmacy providers are also prohibited from billing members for the copay amount or for a prescription that is primary insurance plan exclusion.

Commercial COB

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

- **Confirmation of other insurance coverage:** Confirm other primary insurance coverage status by requesting information from the member. If you are still unable to determine primary pharmacy coverage status from the member, call CenCal Health Member Services at (877) 814-1861 for additional assistance.
- **Claims submission when other insurance confirmed:** If the pharmacy determines that the member does have other pharmacy insurance coverage, the pharmacy bills the prescription claim to the primary insurance carrier first, before billing MedImpact. If a balance remains after payment by the primary carrier, MedImpact is then billed. These secondary billings will include copayments, deductibles and items not covered by the primary carrier. The secondary billing should include the full amount charged for the item, and the amount paid by the primary insurance carrier. Electronic billings that do not include attachments must be self-certified by entering an appropriate and valid Other Coverage Code as described in the Medi-Cal Provider Manual. However, providers must still be able to readily retrieve all backup documentation including proof of claim submission and payment. If the pharmacy is not equipped to submit secondary billings on-line, they may submit a paper claim to MedImpact by completing a 30-1CZ Pharmacy claim form attached to documentation of the paid amount from the primary

insurance. (Be aware that additional processing charges may be imposed by MedImpact for processing paper claims.) Documentation may be either the primary insurance Explanation of Benefits (EOB), or a copy of the pharmacy's adjudication screen.

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

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

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

Recoveries Unit at (805) 685-9795. Attach a copy of the pharmacy adjudication screen showing the claim was rejected due to “No coverage.” If the pharmacy is unable to produce a copy of the denial, they should call CenCal Health Member Services for assistance at (877) 814-1861. Member Services will then research the primary insurance prescription coverage status and initiate a change to the MedImpact eligibility file if the member is found not to have primary pharmacy insurance coverage.

- **Billing Notes:**

Completion of the 30-1CZ Form: If you are unable to bill electronically and must submit a paper claim, please refer to the Pharmacy Claim Form Completion section in the State Medi-Cal Pharmacy Manual.

Mail All Completed Paper Claims to:

MedImpact Healthcare Systems, Inc.
Operations Dept. Attn: Claims
10680 Treena St., 5th floor
San Diego, CA 92131

Medicare COB

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

- **Drugs and supplies covered under Medicare Part B:** This partial list contains drugs and supplies which are currently covered under Medicare Part B; however, some coverage limitations may apply in accordance with specific Medicare regulations. Pharmacy providers are encouraged to verify coverage through other reference sources and/or by contacting the Medicare fiscal intermediary. Other drugs, medical supplies, biologicals, blood modifiers and nutritional therapies covered by Medicare, and are not on the CenCal Health formulary, will not require a MRF. Please refer to your Medicare Supplier Manual for a detailed listing of these items.

CATEGORY	MEDICARE COVERED DRUGS / SUPPLIES
Diabetic Equipment and Supplies (1)	Blood Glucose Monitors Blood Glucose Testing Strips Lancets Lancet Auto Injectors Reagent Strips
Oral Anti-Cancer Drugs	Busulfan (Myleran) Capecitabine (Xeloda) Cyclophosphamide (Cytoxan) Etoposide (Vepesid) Melphalan (Alkeran) Methotrexate. Temozolomide (Temodar)
Immunosuppressive Drugs (2) (Covered after an organ transplant)	Cyclosporin (Neoral, Sandimmune, Gengraf) Mycophenolate Mofetil (Cellcept) Sirolimus (Rapamune) Tacrolimus (Prograf)

(1) Not covered by Medicare if member is residing in a SNF

(2) Member must have enrolled in Medicare at the time of transplant

- **Medicare Provider Number:** Pharmacy providers must have a Medicare Provider Number to bill Medicare for covered drugs and supplies. To obtain a Medicare Provider Number, providers must contact the National Supplier Clearing House, P.O. Box 100142, Columbus, SC 29292-3142 or by phone at (866) 238-9652.
- **Cigna Medicare Region D:** Provider may contact Medicare at (866) 243-7272 or access the web at www.cignamedicare.com for all questions pertaining to billing and coverage parameters. Providers may call (202) 512-1629 to order a Medicare Supplier Manual.

Claims Submission Procedure for Medicare Covered Drugs/Supplies

- 1) MedImpact's eligibility file will indicate when a member has Medicare Part B coverage and will reject on-line prescription claims for Medicare covered drugs and supplies with the edit message "**Must Bill Medicare.**"
- 2) The pharmacy bills Medicare according to the billing instructions as provided by Medicare.

- 3) Once the Pharmacy has received payment or denial from Medicare, they may then bill for any denied services or for a member's Medicare copay and/or deductible. The claim should be sent to MedImpact electronically or on a Pharmacy claim form (30-1CZ) along with the Medicare EOMB information.

Mail All Completed Paper Claims to:
MedImpact Healthcare Systems, Inc.
Operations Dept. Attn: Claims
10680 Treena St., 5th floor
San Diego, CA 92131



Other Insurance Benefit Information Update

Pharmacies are required to bill other health coverage (OHC) prior to billing CenCal Health. If you find that a member's OHC information is incorrect or missing, please complete this form and mail or fax to the CenCal Health Recoveries unit at (805) 685-9795. Include a copy of the insurance denial letter, explanation of benefits, or printout from the primary carrier reflecting the change.

Please fax to (805) 685-9795

(Please Print)

Date

Pharmacy Name	Phone No.
---------------	-----------

Pharmacy/Contact Name

Member Name: Last	First	Member I.D. No.	Program <input type="checkbox"/> SBHI <input type="checkbox"/> PP2 <input type="checkbox"/> HF
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Remove other health coverage information / pharmacy coverage code:

Member has no pharmacy coverage.

Member's insurance does not cover pharmacy services to LTC facility.

Member has met his / her annual prescription benefit amount of \$ _____ for the year 200 ____ .

Member's insurance has lapsed / terminated. Termination date: _____

Other _____

Remove other health coverage information / pharmacy coverage code:

<input type="checkbox"/> Member has other insurance through:	Carrier Name	Effective Date
	Address	Phone No.

Other _____

Remove other health coverage information / pharmacy coverage code:

Change _____

INTERNAL USE ONLY BELOW THIS LINE

Recovery Staff Action Summary: _____

Date Completed	Recovery Staff Initials
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9. PROVIDER GRIEVANCE SYSTEM

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

Definitions:

Inquiry: A request by a Provider for clarification, or a request for additional information. **Appeal:** An appeal is a request from a Provider to change a previous decision made by CenCal Health. Appeals by Providers are made to MedImpact regarding Medical Request Forms (MRFs).

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

Procedure: Processing Provider Inquiries, Appeals, and Complaints

Receipt and Resolution of a Provider Inquiry

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

Pharmacy Claims Processing Decision:

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

Claim Denial for No MRF:

For pharmacy claims denied for "No MRF," MedImpact will have the Provider submit a MRF. MedImpact staff will review the MRF, and if the MRF is approved, the claim will be processed by MedImpact. If the MRF is denied, the Provider receives the PROVIDER/MEMBER MRF APPEAL PROCESS information sheet containing appeal instructions.

Receipt and Resolution of a Provider Appeal

Pharmacy Claims Appeals

If the original pharmacy claim decision is upheld by MedImpact, the Provider may file an appeal by submitting it in writing or via fax to the Provider Services department at 805-685-9828. The PSQI Manager will log the appeal and forward it to MedImpact for review. MedImpact will respond to the Provider within fifteen (15) business days. Following resolution of the appeal

by MedImpact, the PSQI Manager will enter all pertinent data into the Provider Complaint and Grievance System (PCOGS).

Pharmacy claims contested on the basis of a clinical issue, the necessity for treatment, or the type of treatment proposed or utilized, shall be referred to MedImpact's clinical pharmacist. MedImpact will respond to the Provider within fifteen (15) business days. Following resolution of the appeal by MedImpact, the PSQI Manager will enter all pertinent data into the Provider Complaint and Grievance System (PCOGS).

MRF Appeals

If a Provider receives a letter of denial, deferral, or modification of a MRF, the Provider may contact the MedImpact clinical pharmacist responsible for the decision by calling the telephone number or writing to the address on the denial, deferral, or modification notification.

First-level appeals: Providers may appeal denied or modified MRFs by submitting the following documentation within sixty (60) calendar days from the date of the original decision:

- A copy of the original MRF;
- A copy of the denial/deferral/modification notification;
- A letter stating why denial or modification should be overturned;
- Documentation to support overturning the original denial or modification.

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

The Provider will receive a written response within thirty (30) working days of receipt regarding the determination of the first-level appeal. If a decision cannot be reached within thirty (30) working days, notice will be provided to the Provider of the reason for the delay, and a written decision will be issued within fifteen (15) additional days.

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

CenCal Health
Member Services Department
110 Castilian Drive, Goleta, CA 93117
1-877-814-1861 (Toll-Free)

or

805-685-4131 Telecommunications Device for the Hearing Impaired
8:00 a.m. to 5:00 p.m. - Monday through Friday

First-level pharmacy appeals shall be reviewed by a qualified licensed pharmacist who may reverse the decision.

If the original decision is upheld, the Provider may request a second-level appeal. Second-level MRF appeals must be submitted within thirty (30) calendar days from the date of the first-level appeal denial or modification to the Health Services Department at the following address:

CenCal Health
Health Services Department
110 Castilian Dr., Goleta, CA 93117

The following documentation must be submitted with second-level appeals:

- Copy of original MRF and original denial/deferral/modification notification;
- Copy of first-level appeal response letter;
- Letter stating why the first-level appeal denial or modification should be overturned;
- Documents supporting overturning the first-level appeal denial or modification (Providers are encouraged to submit copies of MRFs with the appeal to show prior MRF approval or errors in MRF information).

Providers are notified of receipt of the second-level appeal and the appeals process within five (5) working days.

A physician not involved in the previous determination with a same/similar specialty (as appropriate) reviews the second-level appeal.

The Provider will receive a written response within thirty (30) calendar days of receipt regarding the final determination of the appeal.

CenCal Health informs Members that it is their right to obtain an independent third party review to appeal an adverse determination that is based on medical necessity, and Members are informed of how to do so. CenCal Health may elect to bypass one or more levels of internal review and proceed to an independent review. The decision of the external review body is binding on CenCal Health.

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

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

Following the final resolution of the MRF appeal, the appropriate Health Services staff shall log all pertinent data.

For additional information about MRF appeals, call 805-685-9525, extension 1640.

Receipt and Resolution of a Provider Complaint

Provider Complaints

Complaints related to any aspect of the pharmacy benefit must be submitted to the PSQI Manager in writing or by faxing it to 805-685-9828.

The Director of Provider Services assigns the investigation to the PSQI Manager, who works with MedImpact and CenCal Health staff as indicated to respond to the complaint, either by telephone or in writing within thirty (30) days of receipt of the complaint.

The PSQI Manager shall consult with the Health Services Quality Management Specialist regarding a clinical or quality of care issue. The Quality Management Specialist will attempt, under the direction of CenCal Health's Medical Director, or designee, to respond to the issue as quickly as possible in a time frame appropriate to the member's medical condition.

Following resolution of the complaint with the Provider, the PSQI Manager will enter all pertinent data into the PCOGs. Complaints in which a provider has reported an adverse or potentially adverse effect on a member's quality of care will be referred to the Health Services Department for clinical quality of care review.

Provider Complaints Requiring Clinical Quality of Care Review

CenCal Health's Quality Management Specialist shall be responsible for reviewing clinical complaints in which a Provider has reported an adverse or potentially adverse effect on a member's health.

The Quality Management Specialist shall:

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

Disclosure to Providers and Members

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

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

If the Provider's complaint or appeal has not been satisfactorily resolved by CenCal Health, or a complaint or appeal remains unresolved for more than thirty (30) days without written notice, the Provider may submit the complaint or appeal in writing to CenCal Health's Chief Executive Officer (or designee) who will determine whether it warrants review by the Board of Directors. If the Provider's request involves an exception to DHS or DMHC regulations, the Provider must include justification for such an exception in order for it to be presented to the Board of Directors. CenCal Health's grievance system is in addition to any other dispute resolution procedures available to the Provider. The Provider's failure to

use these procedures does not preclude the Provider's use of any other remedy provided by law.

CenCal Health's Deputy Executive Director should be notified immediately when a Provider's legal representative contacts CenCal Health regarding the pursuit of legal action to resolve a complaint or appeal.

Confidentiality and Privacy Regarding Record Retention

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

Monitoring of the Process

Reports

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

Annual Review

This policy will be reviewed and revised annually, approved by the Network Management Committee, and forwarded to the Healthcare Operations Committee.



Provider Grievance Form

INSTRUCTIONS

CenCal Health makes a grievance resolution process available to providers in accordance with various regulations that govern the healthplan. These grievances, or disputes, may take various forms, including, but not limited to, the following: inquiries (a request for assistance, clarification, or information), appeals (requests to change a previous decision, i.e. regarding Authorization Requests, Medical Authorization Requests, or claims), or complaints (an expression of dissatisfaction). In order to be effectively addressed, we have provided this form for providers to use when submitting grievances to CenCal Health. If submitting a grievance, please complete this form, attach all supporting documentation, and clearly describe the reason for your grievance. Grievances lacking information required for resolution will be returned to you with a request for more information.

CenCal Health requests that you file an appeal only in situations where CenCal Health has received all documentation required to make a decision and you are now requesting reconsideration of that decision due to extenuating circumstances. Do not submit this form as an appeal if a claim was denied for lack of documentation, if your grievance concerns an issue that is older than 365 days from CenCal Health's last action, or if there has been a simple clerical error that could easily be resolved by our Claims staff.

If your grievance is a billing or payment dispute or claims appeal, please submit this completed form with all supporting documentation attached to:

*CenCal Health, 110 Castilian Drive, Goleta, CA 93117-3028,
ATTENTION: Adjudication Dept.*

The mailing address for submitting all other provider grievances is:

*CenCal Health, 110 Castilian Drive, Goleta, CA 93117-3028,
ATTENTION: Provider Services Dept.*

Please do not submit grievances via e-mail as the protections may not meet federal healthcare privacy standards and this method does not adequately allow for supporting documentation. CenCal Health will acknowledge receipt of your grievance within 15 business days and send a written resolution to your grievance within 45 business days after the date of receipt.

Provider Name:		Provider Tax ID#:				
		Provider License #:				
Provider Address:						
Provider Type: <input type="checkbox"/> PCP <input type="checkbox"/> Referral- Specialty _____ <input type="checkbox"/> Hospital <input type="checkbox"/> LTC <input type="checkbox"/> Pharmacy <input type="checkbox"/> DME- Type _____ <input type="checkbox"/> Other _____						
Name of person submitting grievance:		Relationship to provider: <input type="checkbox"/> Self <input type="checkbox"/> Office staff <input type="checkbox"/> Billing service <input type="checkbox"/> Other _____				
Address of person submitting grievance:			Phone #:			
Grievance Type: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> Inquiry <input type="checkbox"/> Benefit <input type="checkbox"/> Contract <input type="checkbox"/> Reimbursement Rate <input type="checkbox"/> Claims Adjudication (EOB assistance) <input type="checkbox"/> Other _____ </td> <td style="width: 33%; vertical-align: top;"> Appeal <input type="checkbox"/> Referral Authorization Request (RAF) <input type="checkbox"/> Authorization Request (AR) <input type="checkbox"/> Medical Authorization Form (MRF) <input type="checkbox"/> Claim <input type="checkbox"/> Other _____ </td> <td style="width: 33%; vertical-align: top;"> Complaint (against...) <input type="checkbox"/> Provider <input type="checkbox"/> Member <input type="checkbox"/> CenCal Health <input type="checkbox"/> MedImpact <input type="checkbox"/> PacifiCare Behavioral Health <input type="checkbox"/> Other _____ </td> </tr> </table>				Inquiry <input type="checkbox"/> Benefit <input type="checkbox"/> Contract <input type="checkbox"/> Reimbursement Rate <input type="checkbox"/> Claims Adjudication (EOB assistance) <input type="checkbox"/> Other _____	Appeal <input type="checkbox"/> Referral Authorization Request (RAF) <input type="checkbox"/> Authorization Request (AR) <input type="checkbox"/> Medical Authorization Form (MRF) <input type="checkbox"/> Claim <input type="checkbox"/> Other _____	Complaint (against...) <input type="checkbox"/> Provider <input type="checkbox"/> Member <input type="checkbox"/> CenCal Health <input type="checkbox"/> MedImpact <input type="checkbox"/> PacifiCare Behavioral Health <input type="checkbox"/> Other _____
Inquiry <input type="checkbox"/> Benefit <input type="checkbox"/> Contract <input type="checkbox"/> Reimbursement Rate <input type="checkbox"/> Claims Adjudication (EOB assistance) <input type="checkbox"/> Other _____	Appeal <input type="checkbox"/> Referral Authorization Request (RAF) <input type="checkbox"/> Authorization Request (AR) <input type="checkbox"/> Medical Authorization Form (MRF) <input type="checkbox"/> Claim <input type="checkbox"/> Other _____	Complaint (against...) <input type="checkbox"/> Provider <input type="checkbox"/> Member <input type="checkbox"/> CenCal Health <input type="checkbox"/> MedImpact <input type="checkbox"/> PacifiCare Behavioral Health <input type="checkbox"/> Other _____				
Member Name:		Member ID#:	Claim Control Number(s):			
DOS:						
Description of Dispute (please attach additional pages as needed and include all available supporting documentation):						

10. PHARMACY AUDITS

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

Audit Triggers

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

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