

Community Supports (CS) Referral Form

Medically Tailored Meals (MTM)/Medically- Supportive Food (MSF)		
HCPCS Code	HCPCS Description	Modifier
S5170	Home-delivered prepare meal	U6
S9470	Nutritional Counseling, diet	U6

MTM/ MSF are designed to address nutrition- sensitive conditions. Referrals must come from a member of the established healthcare team (e.g., primary care providers, specialists, inpatient providers, dieticians, RN case managers, hospital social workers, or other members of the clinical care team) or MCP and must include clinical documentation addressing member's nutrition-sensitive condition. All requests must remain tied to documented medical necessity and clinical benefits. (We will not accept referrals from MTM vendors and/or an individual associated with the MTM organization.)

If you are a **contracted provider**, please submit this form through the **Provider Portal**, selecting CS from the specialty dropdown. We will assess the Member's eligibility and respond with next steps or request more information if needed.

Eligibility Criteria

☐ Individuals who have chronic conditions that are nutrition sensitive or other serious health conditions that are nutrition sensitive, including, but not limited to, cancer(s), chronic kidney disease (stages 2–5), heart failure, diabetes or other nutrition-sensitive metabolic conditions, elevated lead levels, end-stage renal disease, human immunodeficiency virus, hypertension, high cholesterol/dyslipidemia, fatty liver, malnutrition, obesity, stroke, high-risk perinatal conditions (including, but not limited to: gestational diabetes, abnormal glucose in pregnancy, gestational hypertension, and pre-eclampsia), anxiety conditions with moderate to severe distress, depression conditions with moderate to severe distress, and other mental/behavioral health disorders with moderate to severe functional impacts.

We have established clinical thresholds (e.g., biomarkers, disease severity) for UM protocols to ensure services are directed to Members most likely to benefit. Please see the clinical thresholds found on page 3 of this referral form.

Select	Authorization	Must Include
☐	Initial Request Must come from a member of the established healthcare team or MCP	- CS Referral Form - Medical Records of a Member's nutrition sensitive conditions from Member's treating physician - Members must meet established clinical threshold (see pp. 3–7)
☐	Reauthorization Request Must come from a member of the established healthcare team or MCP May be granted only when the Member has ongoing active engagement with their primary care or specialty care team.	- CS Referral Form - Certification or documentation from treating clinician of the Member's ongoing engagement with scheduled appointments, prescribed treatments and the overall care plan. - Evidence of meaningful care coordination between the MTM/MSF provider and the member's healthcare team. (E.g. shared progress notes, joint care planning, or confirmed warm hand-offs.) - Proof of nutrition education or counseling during the initial authorization period documented in the members medical record by their physician.
Following approval for MTM, the rendering MTM provider must complete a Registered Dietitian Nutritionist (RDN) assessment.		

To be completed by requestor/ referring provider:

☐ I certify that I currently provide or oversee the Member's medical care in a role identified below and am not acting solely as an employee or contractor of the rendering Medically Tailored Meals provider.

☐ I attest that MTM/MSF services are being requested based on documented medical necessity and not intended solely to address food insecurity.

Referring Provider Role

- | | |
|---|--|
| ☐ Primary Care Provider | ☐ Nurse Practitioner |
| ☐ Treating Specialist | ☐ Physician Assistant |
| ☐ Hospital/Inpatient Physician | |
| ☐ Other (must specify): _____ | |

Referring Organization Name:

Referring Organization NPI:

Referring Individual Name:

Title:

Referring Individual Phone
Number:

Email Address:

Referring Provider Signature

Date

Member Information

Member Name:

DOB:

Medi-Cal ID/CIN:

Preferred Language:

Residential Address:

City:

Zip Code:

Delivery Address (if different from above):

City:

State:

Zip Code:

Primary Phone Number:

Secondary Phone Number:

Alternate Contact Name:

Alt. Contact Phone:

Guardian/Conservator Information: (if applicable)

Guardian First Name:

Guardian Last Name:

Guardian Phone Number:

Desired Menu:

☐ Low Sodium

☐ Heart-Friendly

☐ Renal-Friendly

☐ Diabetes-Friendly

☐ Gluten-Free

☐ Cancer Support

☐ Vegetarian

☐ Pureed

☐ Low Acid

Indicate any known food allergies:

Member's Nutrition- Sensitive Condition(s)/Diagnosis Requiring MTM	
ICD-10 Code	Code Description

Medical Necessity Justification	
Indicate why a therapeutic diet is required	
Indicate why regular food assistance programs are insufficient	
List the expected health benefits	
Indicate the estimated duration of need	

Utilization Management Clinical Thresholds and Referral Screening Guide

We have established clinical thresholds (e.g., biomarkers, disease severity) for UM protocols to ensure services are directed to Members most likely to benefit.

Purpose

This guide is intended to support referral screening and clinical review. Meeting the eligibility criteria does not guarantee approval. All referrals are subject to clinical review and determination of medical necessity in accordance with applicable regulatory requirements and Community Health Group policies.

Documentation Requirements

Documentation submitted must support the eligibility criteria listed below. Additional medical records may be requested if the documentation provided is insufficient to validate eligibility.

Condition	Eligibility Criteria	Provider Checklist (Medical Records Needed to Validate Eligibility)
1. Cancer	• Active cancer	Provide progress notes documenting current status.
2. Cardiovascular Disorders	• Active atherosclerotic cardiovascular disease (ASCVD) OR	Provide progress notes documenting current status.

	Recent hospitalization or procedures for ASCVD.	
3. Chronic Kidney Disease	Stage 3b through Stage 5 chronic kidney disease.	Provide progress notes documenting current status.
4. Asthma	- Severe persistent asthma OR - Recent corticosteroid use or hospitalization.	Provide progress notes documenting current status.
5. Chronic Obstructive Pulmonary Disease or Other Chronic Lung Disorders	- Moderate to very severe chronic obstructive pulmonary disease or other chronic lung disorder OR - Home oxygen use or recent hospitalization.	Provide progress notes documenting current status.
6. Heart Failure (CHF)	- New York Heart Association Functional Class II, III, or IV heart failure OR - Recent hospitalization for CHF	Provide progress notes documenting current status.
7. Diabetes Mellitus	Hemoglobin A1c of 8.5 percent or greater	Provide progress notes documenting current status.
8. Nutrition-Sensitive Metabolic Conditions	- Documented one inherited or acquired metabolic disorder listed below: - Phenylketonuria - Maple syrup urine disease - Galactosemia - Tyrosinemia - Homocystinuria - Organic acidemias - Urea cycle disorders - Glycogen storage diseases - Fatty acid oxidation disorders	Provide progress notes documenting current status.
9. Elevated Lead Levels	Blood lead level meeting the current Centers for Disease Control and Prevention Blood Lead Reference Value of 3.5–5 µg/dL	Provide progress notes documenting current status.

10. End-Stage Renal Disease	• Receiving chronic hemodialysis or peritoneal dialysis.	Provide progress notes documenting current status.
11. Hypertension	• Persistent Stage 2 hypertension with blood pressure of at least 140/90 millimeters of mercury documented during the last two outpatient visits	Provide progress notes documenting current status.
12. High Cholesterol or Dyslipidemia	• Low-density lipoprotein cholesterol of at least 190 milligrams per deciliter despite maximally tolerated lipid-lowering therapy	Provide progress notes documenting current status.
13. Fatty Liver Disease or MASLD/MASH (Metabolic Dysfunction Associated Steatotic Liver Disease/ Metabolic Associated Steatohepatitis)	• Nonalcoholic steatohepatitis with moderate to advanced liver fibrosis	Provide progress notes documenting current status.
14. Malnutrition	• Moderate or severe malnutrition documented by the treating provider or registered dietitian with unintentional weight loss of at least 10 percent within the previous 6 months or body mass index is less than 18.5 kilograms per square meter.	Provide progress notes documenting current status.
15. Obesity	• Body mass index of at least 40 kilograms per square meter with At least two obesity-related chronic conditions from the list below: • Type 2 diabetes mellitus • Prediabetes • Hypertension • Dyslipidemia (high cholesterol or high triglycerides) • Coronary artery disease • Heart failure	Provide progress notes documenting current status.

	• History of ischemic stroke • Peripheral arterial disease OR • Body mass index of at least 35 kilograms per square meter with at least three obesity-related chronic conditions from the list below: • Type 2 diabetes mellitus • Prediabetes • Hypertension • Dyslipidemia (high cholesterol or high triglycerides) • Coronary artery disease • Heart failure • History of ischemic stroke	
16. Stroke	• Stroke within the previous 12 months with persistent neurologic deficit, swallowing impairment, or ongoing rehabilitation.	Provide progress notes documenting current status.
17. Gestational Diabetes/Abnormal glucose tolerance testing during pregnancy	• Gestational diabetes requiring insulin or oral agents OR • Abnormal glucose tolerance testing during pregnancy	Provide progress notes documenting current status.
18. Abnormal Glucose in Pregnancy	• Abnormal glucose tolerance testing during pregnancy	Provide progress notes documenting current status.
19. Gestational Hypertension	• Gestational hypertension diagnosed by the obstetric provider with antihypertensive treatment with at least two antihypertensive medications	Provide progress notes documenting current status.

20. Pre-eclampsia	Confirmed diagnosis of pre-eclampsia	Provide progress notes documenting current status.
21. Anxiety	Moderate to severe anxiety documented by the treating provider using Generalized Anxiety Disorder 7-item Scale (GAD-7) with score of 10 or greater with documented functional impairment	Provide progress notes documenting current status.
22. Depression	Moderate to severe depression documented by the treating provider with Patient Health Questionnaire-9 (PHQ-9) results of 15 or higher with documented functional impairment.	Provide progress notes documenting current status.
23. Chronic or Disabling Mental or Behavioral Health Disorders	Schizophrenia, bipolar disorder, schizoaffective disorder, or another serious mental illness with documented severe functional impairment	Provide progress notes documenting current status.
24. Human Immunodeficiency Virus Infection	Human immunodeficiency virus infection receiving antiretroviral therapy with documented nutrition-related complications with unintentional weight loss, leading to a body mass index less than 20 kilograms per square meter or active opportunistic infection.	Provide progress notes documenting current status.