Santa Clara Family Health Plan
The Spirit of Care

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Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, January 17, 2018
6:00 PM - 7:30 PM
210 E. Hacienda Avenue
Campbell, CA 95008

AGENDA

1.	**Introduction**	Dr. Lin	6:00	5 min.
2.	**Meeting Minutes**	Dr. Lin	6:05	5 min.
	Review minutes of the October 18, 2017 Utilization Management Committee meeting.			
	Possible Action: Approve 10/18/2017 minutes			
3.	**Public Comment**	Dr. Lin	6:10	5 min.
	Members of the public may speak to any item not on the agenda; two minutes per speaker. The Committee reserves the right to limit the duration of public comment period to 30 minutes.			
4.	**CEO Update**	Ms. Tomcala	6:15	10 min.
	Discuss status of current topics and initiatives.			
5.	**Discussion Items/Follow up Items**			
	None			
6.	**Action Items**	Ms. Castillo	6:25	25 min.

a. Hierarchy of UM Criteria
b. Review of Policies
- **i.** HS.01 Prior Authorization
- **ii.** HS.02 Medical Necessity Criteria
- **iii.** HS.03 Appropriate Professionals
- **iv.** HS.04 Denial Notification
- **v.** HS.05 Evaluation of New Tech
- **vi.** HS.06 Emergency Services
- **vii.** HS.07 Clinical Practice Guidelines
- **viii.** HS.08 Second Opinion
- **ix.** HS.09 Interrater Reliability
- **x.** HS.10 Financial Incentive
- **xi.** HS.11 Informed Consent

xii. HS.12 Preventive Health Guidelines
Possible Action: Approve UM policies as presented.

c. UM Program Description 2018
Possible Action: Approve UM Program Description

d. Care Coordinator Guidelines 2018 –
- Discussion of the request to change the Long Term Care authorizations to 6 months vs. 1 year

Possible Action: Approve Care Coordinator Guidelines

7. Reports (MediCal/SPD, Healthy Kids)

a.	Membership	Dr. Robertson	6:50	5 min.
b.	UM Reports 2018	Dr. Boris	6:55	10 min.
	i. Dashboard Metrics: Turn Around Time (Cal MediConnect/Medi-Cal)			
	ii. Standard Utilization: Metrics PowerPoint			
	Follow up items:			
	a. Primary diagnosis for readmits by Line of Business			
	b. CPT codes for all members with bariatric surgery (what was most frequent procedure requested?)			
	c. CMC readmit rates Q12017 was 9%; (review change)			
	d. Data on OB inpatient admissions by hospital			
c.	IRR Behavioral Health	Dr. Boris	7:05	5min.
d.	Annual Specialty Referral Tracking of Procedures HS.01.02	Dr. Boris	7:10	5 min.
e.	HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials, etc. (Q4 17)	Ms. Castillo	7:15	5 min.
f.	Review of the Physician Peer to Peer process	Dr. Boris	7:20	5 min.

8. Adjournment — Dr. Lin — 7:25

Next meeting: Wednesday, April 18, 2018 6 p.m.

Notice to the Public—Meeting Procedures

Persons wishing to address the Utilization Management Committee on any item on the agenda are requested to advise the recorder so that the Chairperson can call on them when the item comes up for discussion.

The Utilization Management Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.

In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Caroline Alexander 48 hours prior to the meeting at 408-874-1835.

To obtain a copy of any supporting document that is available, contact Caroline Alexander at 408-874-1835. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 210 E. Hacienda Avenue, Campbell.

This agenda and meeting documents are available at www.scfhp.com.

Santa Clara Family Health Plan

The Spirit of Care

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
October 18, 2017

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
Ngon Hoang Dinh, DO	Head and Neck Surgery	Y
Indira Vemuri, MD	Pediatrics	Y
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, CMO	Managed Care	N
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	N
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:10 PM. There was a motion to approve the July 19, 2017 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	
IV. CEO Update	Christine Tomcala , CEO discussed the following items: The Santa Clara Family Health Plan received interim NCQA accreditation this year. We are now in the process of obtaining full NCQA accreditation within the next 18 months. The health plan received a Quality award from the state for most improved on DHCS results. SCFHP has purchased a building and will move after build out completed.	None.

ITEM	DISCUSSION	ACTION REQUIRED
V. Discussion Items/Follow Up Items	a. What percentage of those in SNF become Long Term Care As a follow up item from our last meeting, we calculated the LTC conversion from SNF for the time period January 1st 2017 to September 30th 2017. We looked at skilled admissions authorizations requiring Long Term Care authorization for custodial purposes. Of the 773 admitted to Skilled Nursing Facilities, 400 converted to Long Term Care. The UM committee members discussed how high these numbers are. b. Can there be a member service representative script for members changing PCP's (item for follow up from last meeting)? A script currently exists with member services. Detailed workflow that corresponds with the script. Involves notification of eligibility department, changing information in database.	None.
VI. Action Items	a. Prior Authorization Grid CY2018: Ms. Carlson presented the updated Cal MediConnect and Medi-Cal prior authorization grids for 2018. Staff in UM streamlined Medi-Cal and Cal MediConnect items needing prior authorization so it is standardized. Removed neuropsych testing from requiring prior authorization. As per our DHCS CAP finding, we changed PA requirements and removed colonoscopy-removed from Medi-Cal prior authorization grid. Penile implants removed from Medi-Cal authorization grid. SCFHP is no longer requiring preventive procedures have a prior authorization. After further review, initially the motion passed. However Dr. Tobaggi wanted a redline copy of the changes and moved to undo and NOT approve the PA grid changes. SCFHP staff will bring the redline copies to a next meeting for final review and approval. .	Bring redline version of grids to Q12018 UM Committee meeting.
	b. HS.01.08 Non-Emergency Medical Transportation Policy There is a noted error on the agenda. The NEMT is not a Policy but a procedure. Ms. Carlson presented the Non-Emergency Medical Transportation Procedure. Note: Not an action item. Procedure, not policy, presented. DHCS mandated that all health plans had to have transportation services policy in place following a new APL that had been released. Authorization expands Non-Emergency Medical Transportation for public services. Largest change from Utilization Management standpoint is that non-emergency medical transportation ordered by MD requires written attestation for medical necessity by ordering physician.	No action required. Informational only.

ITEM	DISCUSSION	ACTION REQUIRED
VII. Reports	a. Membership Ms. Tomcala presented an update on membership. Membership has remained stable since last report. Lost about 1200 members. Healthy Kids membership is 2288, Medi-Cal 260,518, CMC is 7,326. Compared membership with other health plans across the state. Only county that lost a large amount of membership. May be due to the high cost of living in this county. b. UM Reports 2017 i. Dashboard Metrics Dr. Boris presented the Dashboard Metrics report. For Cal MediConnect, 14 calendar day turnaround time for routine, for urgent 72 hours. Percent of timely decisions made within 14 days is 100% for September. Percent of timely decisions made within 72 hours is 99%. For Medi-Cal, 5 business day turnaround time for routine, for urgent 72 hours. Percent of timely decisions made within 5 business days of request is 100% for September. Percent of timely decisions made within 72 hours of request is 98.6% for September. ii. Standard Utilization Deferred to 1st Quarter 2018. c. Interrater Reliability (IRR, Q3) Dr. Boris presented the Interrater Reliability report for 3rd Quarter 2017. In accordance with Policy HS.09, the 2nd bi-annual Calendar Year 2017, Santa Clara Family Health Plan (SCFHP) scheduled IRR testing is complete. This is required twice a year. IRR testing is scheduled for SCFHP 1st and 2nd half of the calendar year. In accordance with NCQA/DHCS, DMHC guidelines, and SCFHP policy, 10 random UM authorizations are selected to test all of our Utilization Management (UM) staff. Our UM staff consist of non-licensed Care Coordinators (CC), RN/LVN, and Medical Directors (MD). LTSS staff included. Test all functions. In the 2nd testing, 63% or 10/16 of staff are proficient while the remaining 37% or 6/16 are not proficient and will require remediation. Inability to identify line of business was most common deficiency. The corrective action plan after identifying the common findings are mandatory remedial training scheduled for October 25th as well as mandatory bi-annual review of guidelines and criteria. d. Annual Specialty Referral Tracking of Procedures HS.01.02 Deferred to 1st Quarter 2018.	SCFHP is working to add timeliness of letter notification to report.

ITEM	DISCUSSION	ACTION REQUIRED
	e. Annual Out of Network Report YTD 2017 Dr. Boris presented the Annual Out of Network Report for 2017. Based on authorizations. Review annually the utilization of out of network services. All networks from 4/2016 to 9/2017. The top three were Acute Hospital at 34%, Ambulatory Surgery Center at 10%, and Family Practice plus Internal Medicine at 9%. Recommend look at hospitalizations less than 2 days. A description of the OON report is as follows: for the 18 month time period studied, the OON report shows the following trends: 1. 34% of OON network utilization is for members using acute non contracted hospitals. 2. Two hospitals Regional Medical Center and UCSF account for 56% of the utilization 3. Inpatient approved authorizations are largely through the Emergency Room. This was 100% true for UCSF. 4. For UCSF: the 23 outpatient authorizations were for a. 11 authorizations were for 3 patients (well known to UM Medical Directors). b. 3 authorizations were requested by second opinion from Stanford. c. 2 authorizations were overturns after a Peer to Peer discussion occurred. d. This accounts for 70% of the UCSF elective outpatient authorizations. 5. For the second category of authorizations to freestanding ASC's. Bay Area Surgery Centers has been contracted. 6. For the Family Practice / Internal Medicine categories: it was discovered that when the migration of authorizations occurred from Xpress to QNXT in June 2012, these providers initially showed as non-contracted. This has since been corrected. Recommendations - The Plan continues its efforts to contract with RMC. The plan is pursuing standing Letters of Agreement with CA surgicenter Mountain View, Surgicenter of Palo Alto, and Peninsula eye surgery center since these facilities are preferred by providers in Sutter's Palo Alto Medical Foundation (PAMF). The plan has recently completed a standing LOA agreement with Fremont Ambulatory Surgery Center. f. HS.04.01 Reporting Quality Monitoring of Plan Auths, Denials, etc. (Q2 & Q3) Dr. Boris presented the Quality Monitoring Report for 2nd and 3rd Quarter 2017. Quality Monitoring of Plan Authorizations, Denials, etc. For the 2nd quarter review of 2017, the findings are as follows: For the dates of services and denials for April, May and June of CY 2017 were pulled in the 2nd quarter sampling year. 30 unique authorizations were pulled with a random sampling. ▪ 50% or 15/30 Medi-Cal and 50% or 15/30 CMC ▪ Of the sample 100% or 30/30 were denials ▪ Of the sample 37% or 11/30 were expedited; 63% or 19/30 were standard	

ITEM	DISCUSSION	ACTION REQUIRED
	• 100% or 11/11 of the expedited authorizations were processed within 72 calendar hours • 95% or 18/19 of the standard authorizations met timeliness factors o Case was Member Initiated Org Determination ▪ 53% or 16/30 of the denials were medical necessity denials ▪ 57% or 14/30 of the denials were Non-Contracted Providers redirect back into network ▪ 100% or 30/30 of cases received physician review, or pharmacist reviewer ▪ 100% or 30/30 of the files had the correct letter template ▪ 100% or 30/30 have evidence of clear denial language. For the 3rd quarter review of 2017, the findings are as follows: For the dates of services and denials for July, August, and September of CY 2017 were pulled in the 3rd quarter sampling year. 30 unique authorizations were pulled with a random sampling. ▪ 50% or 15/30 Medi-Cal LOB and 50% or 15/30 CMC LOB ▪ Of the sample 100% or 30/30 were denials ▪ Of the sample 37% or 11/30 were expedited request; 63% or 19/30 were standard request • 100% or 11/11 of the expedited authorizations were processed within 72 calendar hours • 100% or 19/19 of the standard authorizations met regulatory TAT ▪ 47% or 14/30 of the denied auth did not meet medical necessity ▪ 53% or 16/30 of the denials were Non-Contracted Providers with services available in network or non-covered benefit. ▪ 100% or 30/30 of cases were denied by MD or pharmacist. ▪ 100% or 30/30 of the files had the correct letter template ▪ 100% or 30/30 have evidence of clear denial language. g. Quarterly RN advice line statistics (CMC and Medi-Cal) Ms. Carlson presented the RN Advice line statistics report. Total calls to Nurse Advice Line for July 1, 2017 thru September 30, 2017 is 38. Total calls to Nurse Advice Line for September 1 to September 30th, 2017 is 664. Age range specific to calls: Age 0-17 years of age: 216 Age 18 to 75 years of age and above: 449 Many are just customer service calls such as requests for transportation.	

ITEM	DISCUSSION	ACTION REQUIRED
	h. Notice to MD offices about RN Advice Line Care Net provides RN advice line to both lines of business. All dispositions will be communicated same day to case management team. Provide more education to primary care physicians and members on when to use Nurse Advice Line.	
VIII. Adjournment	Meeting adjourned at ____7:35 PM__	
NEXT MEETING	The next meeting is scheduled for Wednesday, January 17, 2018, 6:00 PM	

Prepared by:

_____ Date _____
Caroline Alexander
Administrative Assistant

Reviewed and approved by:

_____ Date _____
Jimmy Lin, M.D.
Committee Chairperson

PROCEDURE

Santa Clara
Family Health Plan

Procedure Title:	**Application of Clinical Criteria**	**Procedure No.:**	HS.02.01
Replaces Procedure Title (if applicable):	None	**Replaces Procedure No. (if applicable):**	None
Issuing Department:	Health Service	**Procedure Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define the hierarchy to follow when applying utilization management criteria, by line of business, for prior authorization determinations.

II. Procedure

1. Utilization review determinations function from a consistently applied, systematic evaluation of utilization management decision criteria.
2. The medical necessity review criteria adopted shall be selected based on nationally recognized and evidence-based standards of practice for medical services and are applied on an individual needs basis.
    a. Criteria is available to practitioners, providers, members and the public by request
    b. Criteria is adopted at least annually by the UM Committee
3. Specific to the Cal MediConnect (CMC) Medicare members, primary criteria used for utilization review decisions shall be first considered through Noridian, National Coverage Determinations (NCD), MCG and other nationally recognized standards of practice.
    a. When criteria is utilized outside of Noridian and NCD, the Plan will never apply a more restrictive than Medicare guidelines allow
4. A hierarchy of criteria for UM decision shall be used as listed below. Other applicable publicly available clinical guidelines from recognized medical authorities are referenced, when indicated.
5. As applicable, government manuals, statutes, and laws are referenced in the medical necessity decision making process.
6. Only a physician, pharmacist or designated behavioral health practitioner may apply medical necessity criteria to a modification or denial decision
7. UM consider at least the following individual characteristics when applying criteria:
    a. Age
    b. Comorbidities
    c. Complications
    d. Progress of treatment
    e. Psychosocial situation
    f. Home environment, when applicable
8. UM considers available services within network and their ability to meet member's specific health care needs when UM criteria are applied such as:
    a. Availability of inpatient outpatient and transitional facilities.

b. Availability of outpatient services in lieu of inpatient services such as surgicenters vs. inpatient surgery.
c. Availability of highly specialized services, such as transplant facilities or cancer centers.
d. Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge.
e. Local hospitals' ability to provide all recommended services within the estimated length of stay.

UM Criteria	Medi-Cal/Healthy Kids	CMC Medicare
Outpatient (all)	A. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) B. MCG Guidelines C. SCFHP UM approved policies D. Consensus statements and nationally recognized standards of practice (if no other guidelines available)	A. Noridian Medicare Portal (California jurisdictions: D&E only) B. National Coverage Determinations C. MCG Guidelines D. Applicable Medicare Manual D. Consensus statements and nationally recognized standards of practice (if no other guidelines available)
Inpatient	A. MCG Guidelines	A. MCG Guidelines
Cancer Related Services	A. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) B. NCCN (National Comprehensive Cancer Network) guidelines.	A. Noridian B. National Coverage Determinations C. NCCN (National Comprehensive Cancer Network) guidelines. D. Applicable Medicare Manual E. D. Consensus statements and nationally recognized standards of practice (if no other guidelines available)

PROCEDURE

California Home Medical Equipment (DME Vendor)	A. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) B. MCG Guidelines C. Nationally recognized standards of practice (if no other guidelines available)	A. Noridian B. National Coverage Determinations C. MCG Guidelines (Milliman) D. Applicable Medicare Manual E. Consensus statements and nationally recognized standards of practice (if no other guidelines available)
Medications	A. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) B. MCG Guidelines C. SCFHP Pharmacy criteria C. Nationally recognized standards of practice (if no other guidelines available)	A. Noridian B. National Coverage Determinations C. MCG guidelines D. SCFHP Pharmacy criteria E. Micromedex F. Applicable Medicare Manual G. Consensus statements and nationally recognized standards of practice (if no

PROCEDURE

UM Criteria	Medi-Cal/Healthy Kids	CMC Medicare
Investigative or Experimental Devices or Technology **Investigative or Experimental Medication**	A. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) B. MCG Guidelines C. Nationally recognized standards of practice (if no other guidelines available)	A. Up to date (website) B. Appointed special work group composed of the Medical Director and Board Certified specialists specific to the need of the request C. Reviewed through the P&T Committee or appointed special work group to assess

9. Monitoring for compliance of applying medical necessity criteria is accomplished through
    a. Inter Rater Reliability reviews
    b. Member Appeals and Grievances
    c. Provider Complaints and disputes
10. UM criteria are reviewed annually and updated when appropriate.
11. UM gives practitioners with clinical expertise in the area being reviewed, the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria through UM committee or distributing applicable criteria to applicable practitioners.
12. Providers may obtain UM criteria by requesting from UM department through fax, phone, or in-person, and will be sent via fax, email or mail.
13. Faxed and phone requests are received and processed in the UM Department. All requests are logged in a spreadsheet and stored in the UM Department share drive. For in-person requests received through another department, requests will be forwarded to the UM team.

III. Policy Reference

HS.02 Medical Necessity Criteria

IV. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature Sandra Carlson, RN Name Director of Medical Management Title 10/20/17 Date	Jeff Robertson MD Signature Jeff Robertson, MD Name Chief Medical Officer Title 10/20/17 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original/Revised			

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Prior-authorization/Org determinations**	**Policy No.:**	HS.01
Replaces Policy Title (if applicable):	Prior Auth for Non-Delegated SCFHP Mbrs., MLTSS Specialty Programs Prior Auth Process; Prior Authorization Process Continuity of Care Policy, Out of Network, Out of Area Referrals	**Replaces Policy No. (if applicable):**	UM002_07; UM002_09; UM002_08; UM031_04; UM033_04
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define consistent processes and guidelines for conducting prior authorization / organization determinations.

II. Policy

A. Santa Clara Family Health Plan has developed, maintains, continuously improves and annually reviews a Utilization Management Program. The UM Program Description and written procedures addresses required functions to support the consistent application of criteria.

B. Prior Authorization is not required for Emergency Services (including Emergency Behavioral Health Services), Urgent care, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

1. The Plan applies the prudent layperson or reasonable person's interpretation of what may be considered an emergent condition. A policy regarding coverage of emergency services is maintained, revised and reviewed annually and as needed.

C. Prior Authorization is not required for inpatient admissions for stabilization after emergency room treatment

D. Prior authorization is required for inpatient admissions and post stabilization admission in and out-of-network

1. A member or member's representative can initiate prior authorization requests. In this case, the request is processed the same as a provider service request.

E. The Plan utilizes standardized criteria for medical necessity determinations and maintains a policy that is reviewed annually.

F. The Plan has established turn-around times for each line of business which is monitored for compliance

    1. Decisions are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. In addition, all decisions are clearly documented.

G. The plan allows for new members to continue services with out-of-network providers for a defined period of time in order to facilitate a smooth transition of care into the Plan's network as specified in Continuity of Care benefit.

H. The Plan maintains a protocol regarding Continuity of Care for both medical and behavioral health services.

I. Out of Area requests are processed in accordance to the Plan's Continuity of Care protocol for medical and behavioral health

J. Members and providers have access to the Utilization Management Department at least eight hours a day during normal business hours of at least 8:30 a.m. to 5:00 p.m. Pacific Time. The Nurse Line is available after hours for timely authorization of covered services that are Medically Necessary and to coordinate transfer of stabilized members in the emergency department, if necessary.

    1. The Plan gathers all relevant information in order to make a prior authorization determination. This includes considerations outside of the clinical information such as support system, other resources and location.

K. The Plan maintains a policy and procedure for allowing members access to a second opinion

L. The Plan maintains a policy on denials and denial notification

M. The Pan maintains a policy on requiring use of appropriate/qualified professionals for UM functions such as

    1. Licensed vs. non-licensed functions
    2. Specialist requirements (BH, other)

N. The Plan maintains policy and procedures to make certain that members have equal access to new technology or new uses of current treatment modalities through an established policy for the evaluation of new technology.

III. Responsibilities

Health Services collaborates with internal and external stakeholders to ensure optimal utilization management of services for plan members. This includes working with of Quality, Benefits, IT, Provider and Member Services, outside community resources and providers.

POLICY

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title January 18, 2017	Title January 18, 2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	**Original**	**Utilization Management**	**Approved/1/18/17**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Medical Necessity Criteria	**Policy No.:**	HS.02
Replaces Policy Title (if applicable):	Clinical Decision Criteria and Application Policy; Utilization Management Review Standards, Criteria and Guidelines; UM Interrater Reliability Testing	**Replaces Policy No. (if applicable):**	CSCFHP_UM121_01; UM039_02 UM038_
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's use of Medical Necessity Criteria for utilization management activities, which includes the mandate that they are applied appropriately and consistently to determinations of medical necessity of coverage.

II. Policy

The Plan maintains a Utilization Management (UM) Program description and Prior Authorization Procedure which further describe the Plan's utilization of Medical Necessity Criteria. The following factors apply:

A. Criteria is based on sound clinical evidence to make utilization decisions
B. Criteria is specific to procedures
C. Criteria is used to evaluate the necessity of medical and behavioral healthcare decisions
D. In addition to the UM hierarchy of guidelines, the Plan is licensed to use MCG™ guidelines (formerly known as Milliman Care Guidelines®) to guide utilization management decisions
E. The criteria is reviewed and adopted at least annually by the UM Committee
    1. This includes external physicians, both primary care providers and specialists (including pediatric and behavioral health specialists) in developing, adopting, and reviewing criteria
F. The criteria takes into account individual member needs and the local delivery system
G. The Plan annually defines the hierarchy of application of criteria for each line of business
H. The plan defines the availability of criteria and states in writing how practitioners can obtain UM criteria and how the criteria is made available to the practitioners and members upon request
I. The plan evaluates the consistency with which health care professionals involved with any level of applying UM criteria in decision making and takes appropriate corrective actions to improve areas of non-compliance at least annually

J. Where applicable, UM criteria is developed for parity diagnoses, for the diagnosis and treatment of serious mental illnesses, autistic disorders, and other pervasive-developmental disorders and serious emotional disturbances of a child.

1. This includes criteria consistent with standards of practice for the following mental parity conditions: Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major Depressive Disorders, Panic disorder, Obsessive-compulsive disorder, Pervasive developmental disorder or autism, Anorexia Nervosa, Bulimia Nervosa and Severe Emotional Disturbances of Children.

2. When SCFHP discloses medical necessity criteria to the public, the criteria includes the following disclosure: "The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

III. Responsibilities

Health Services reviews annually and submits criteria, policies and procedures to the medical officer and UM/QIC for approval.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature Sandra Carlson Name Health Services Director Title 01/18/2017 Date	Jeff Robertson MD Signature Jeff Robertson, MD Name Chief Medical Officer Title 01/18/2017 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 4/20/2016**	
	Original	**Utilization Management**	**Approve 01/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Appropriate Use of Professionals**	**Policy No.:**	HS.03
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To provide clear directives that utilization management activities are carried out by qualified personnel, not limited to but including utilization of licensed healthcare professionals for any determination requiring clinical judgment.

II. Policy

A. Santa Clara Family Health Plan's Health Services Department carries out various utilization management activities which require different levels of licensure or expertise.
B. The Plan specifies the type of personnel responsible for each level of UM decision making which includes:
    - Non-licensed staff may apply established and adopted UM approval guidelines that do not require clinical judgment.
    - Only qualified licensed healthcare professionals assess clinical information used to support UM decisions.
    - Only a physician, designated behavioral health practitioner or pharmacist may make a medical necessity denial decision.

C. Licensed professionals supervise all medical necessity decisions and provide day to day supervision of assigned UM staff.
D. Non-licensed and licensed staff receive training and daily supervision.
E. The Plan maintains written job descriptions with qualifications for practitioners who review denials based on medical necessity which addresses education, training, experience and current appropriate clinical licensure.
F. SCFHP maintains a fulltime Medical Director and Chief Medical Officer. Each maintain an un-restricted physician license in the state of California.
G. The Plan requires that each UM denial file includes the reviewer's initial, unique electronic signature, identifier or a signed / initialed note by the UM staff person attributing the denial decision to the professional who reviewed and decided the case.

H. The plan maintains written procedures for using board certified consultants to assist in making medical necessity determinations which documents evidence of the use of the consultants when applicable.
I. The Plan maintains a Policy prohibiting financial incentives for UM decisions, including incentives to deny requests or to encourage underutilization.

III. Responsibilities

Health Services follows appropriate professionals supported by Human Resources for licensing verification and Provider Network Management monitoring of the professional licensing organizations.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN	
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title 01/18/2017	Title 01/08/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1		**Utilization Management**	**Approve 01/08/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Denial of Services Notification**	**Policy No.:**	HS.04
Replaces Policy Title (if applicable):	Member Notification about Adverse Medical Service Decisions	**Replaces Policy No. (if applicable):**	UM-01-96
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's expectations for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations.

II. Policy

A. The plan maintains strict processes on notification of denial decisions to members and providers. Notification includes verbal and written processes. A procedure is maintained that outlines timeliness guidelines that are followed by Health Services.

B. A "peer to peer" review mechanism is in place to allow providers to discuss a denial with a physician reviewer prior to submitting an appeal. This is documented when such discussions occur.

C. Letters to members for denial, delay, or modification of all or part of the requested service include the following.

1. Approved templates are customized to each line of business and filled out appropriately for each member request
2. Specifies the denied or modified service or care requested and provides a clear and concise explanation of the reason(s) for the Plan's decision
3. Specifies the criteria or guidelines used for the Plan's decision
4. Specifies the clinical reason(s) or rationale for the Plan's decision without the use of detailed medical verbiage and/or technical language.
5. If the denial is due to not enough clinical information to support full clinical review, the letter specifies the information needed and the specific criterion used
6. Advises that upon request, members and providers can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
7. The letter and member specific language for reason of denial is easily understood for a layperson
8. Provided in the language noted on the member's plan file
9. Advises that notifications are available in threshold languages upon request
10. Advises that translation services in alternative formats can be requested for members with limited language proficiency

11. The written notification to the requesting provider includes the name of the determining health care professional as well as the telephone number to allow the physician or provider to easily contact the determining health care professional
12. The Plan's written denial notification to members and their treating practitioners contains the following information relevant to the appeal

    i. A description of appeal rights, including the right to submit written comments; documents or other information relevant to the appeal
    ii. An explanation of the appeal process; including members' rights to representation and appeal time frames
    iii. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials
    iv. A description on how to appeal to the Independent Medical Review body appropriate to their line of business (i.e. State DMHC for MediCal, Maximus for Medicare non pharmacy)

III. Responsibilities

Health Services coordinates with both internal and external stakeholders in development, execution, maintenance and revisions to Denial Notifications. This includes but is not limited to collaboration with Quality, Benefits, IT, UM Committee, QIC, providers and community resources.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN	
Signature **Sandra Carlson, RN**	Signature Jeff Robertson, MD
Name **Director of Health Services**	Name Chief Medical Officer
Title **01/18/2017**	Title 01/18/2017
Date	Date

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v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Evaluation of New Technology**	**Policy No.:**	HS.05
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's process used where members have equitable access to new technology or new developments in technology that is determined to be safe and effective as aligned with benefits.

II. Policy

A. The Plan establishes and maintains a formal mechanism for selective evaluation and adoption of new or innovative technologies.
   1. New developments in technology and new applications of existing technology is necessary for inclusion considerations in its benefits plan as allowed, to keep pace with changes in the industry and allow for improved outcomes of medical care.

B. The Plan maintains written processes for evaluating new technology and new applications of existing technologies for inclusion in its benefits, where allowed by payors. Processes will address assessment of new technologies for medical procedures, behavioral health procedures, pharmaceuticals, and devices.

C. The Plan investigates all requests for new technology or a new application of existing technology by using Up to Date as a primary guideline to determine if the technology is considered investigational in nature.
   1. Up to Date is an evidence-based clinical decision support resource for healthcare practitioners. If further information is needed, the plan utilizes additional sources, include Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. Pharmaceuticals are investigated by the Pharmacy and Therapeutics Working Group.

D. If the new technology, pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director's critical evaluation will proceed to conferring with an appropriate specialist consultant for additional information.

E. If the new technology, pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director's critical evaluation will proceed to conferring with an appropriate specialist consultant for additional information.

III. Responsibilities

Health Services coordinates efforts with internal stakeholders to ensure new technology is assessed for regulatory appropriateness and efficacy. Benefit changes are coordinated with IT and compliance.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title 01/18/2017	Title 01/18/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Emergency Services**	**Policy No.:**	HS.06
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define coverage of Emergency Medical Conditions and Urgent Care services.

II. Policy

A. Emergency Services are available and accessible within the service area 24 hours-a-day, seven (7) days-a-week
B. The Plan maintains contracts with behavioral health practitioners and facilities to provide services to members that require urgent or emergent Behavioral Healthcare for crisis intervention and stabilization
C. SCFHP includes ambulance services for the area served to transport the member to the nearest 24-hour emergency facility with physician coverage
D. The Plan does not require prior authorization for access to Emergency Services
E. The Plan does not require prior authorization for Urgent services for contracted and non contracted providers.
F. The Plan applies prudent layperson language to define emergency department access and assesses each case on the presenting symptoms or conditions that steered the member to the Emergency Department.
G. No authorization is required for emergency services
    i. To screen and stabilize the member
    ii. Should a member be directed to the ED by an agent of SCFHP (i.e. contracted PCP or specialist, nurse advice line, customer service, etc.) then the ED service will be approved regardless of prudent layperson language.
H. In the occasion where an Emergency Department visit was to be denied, that denial must be made by a physician reviewer (except in administrative circumstances such as the claimant was not a member at the time of service).
I. It is the policy of SCFHP to allow 24-hour access for members and providers to obtain timely authorization for medically necessary care where the member has received emergency services and the care has been stabilized but the treating physician feels that member may not be discharged safely
J. SCFHP does not require prior authorization for the provision of emergency services and care necessary to stabilize the member's medical condition.
K. The Plan will not deny reimbursement of a provider for a medical screening examination in the Emergency Department

L. If the Plan and the treating provider disagree about the need for post-stabilization care, then the Plan provider will personally take over the care of the patient within a reasonable amount of time for post-stabilization care or the Plan will have another hospital agree to accept the transfer of the member

M. The Plan makes the Emergency Department utilization management processes available to all facilities, including non-contracting hospitals by
   i. Posting on the Plan website for public view
   ii. Providing the number on the membership card M. All ED practices are considered at least annually

III. Responsibilities

Health Services collaborates internally with benefits, compliance and IT to ensure that emergency services are covered.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title 01/18/2017	Title 01/18/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
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Santa Clara
Family Health Plan

Policy Title:	**Clinical Practice Guidelines**	**Policy No.:**	HS07
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define the manner of a consistent process for development and revisions of Clinical Practice Guidelines.

II. Policy

A. Santa Clara Family Health Plan (SCFHP) uses Clinical Practice Guidelines to help guide practitioners to make decisions about appropriate health care for specific clinical circumstances and behavioral healthcare services. These guidelines are based on up to date evidence and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field.

B. SCFHP adopts at least two medical based and two behavioral health based clinical practice guidelines.

C. The guidelines are reviewed and updated at least every two years by the Utilization Management Committee (UMC).

D. The CPGs are available for viewing on the provider web page of the health plan website, are available in the Provider Manual and are available upon request.

E. In addition to the Clinical Practice Guidelines, The Plan adopts preventive health guidelines for the following:
   1. Care for children up to 24 months old
   2. Care for children 2-19 years old
   3. Care for adults 20-64 years old
   4. Care for adults over 65 years old

F. SCFHP annually measures performance against at least two important aspects of the disease management programs

G. SCFHP annually evaluates provider adherence to CPGs and Preventive Health Guidelines through analysis demonstrating a valid methodology to collect data.
The QI Department analyzes pertinent HEDIS scores and claims data.
The analysis includes quantitative and qualitative analysis or performance.

Member satisfaction and grievances are tracked and reported to the Quality Improvement Committee (QIC) at least annually and acted upon as recommended by the QIC.

III. Policy Reference

HS.07 Clinical Practice Guidelines

IV. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN	
Signature	Signature
Sandra Carlson	Jeff Robertson, MD
Name	Name
Director of Health Services	Chief Medical Officer
Title	Title
January 18, 2017	January 18, 2017
Date	Date

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v1.0		**Utilization Management**	**1/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Second Opinion	**Policy No.:**	HS.08
Replaces Policy Title (if applicable):	Second Opinion Policy and Procedure	**Replaces Policy No. (if applicable):**	UM-30-96; UM036_01
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☐ CMC

I. Purpose

To define the process of obtaining second opinions and member access to a second opinion by appropriate healthcare professionals as appropriate.

II. Policy

A. A request for a second opinion may be initiated by a member or a treating healthcare provider of a member
B. The member Evidence of Coverage provides all members with notice of the policy regarding the manner in which a member may receive a second medical opinion.
C. The Plan provides or authorizes a second opinion by an appropriately qualified health care professional, if requested by a member or participating health professional.
D. When 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 lack of timeliness would be detrimental to the enrollee's ability to regain maximum function, the Plan will authorize or deny the second opinion request within 72 hours.
E. When the member's condition is non-urgent, the Plan authorizes or denies the second opinion requests in an expeditious manner not to exceed the usual UM policy.
F. The member may choose from any provider from any independent practice association or medical group within the network of the same or equivalent specialty to provide the second opinion
G. If the member requests a second opinion from an out-of-network specialist which is approved by the Plan, the Plan shall incur the cost for the second opinion beyond the applicable co-pays due by the member, if any.
H. The Plan shall notify the member of any denial for a second opinion in writing. If an expedited request, the member will be notified in alignment with established UM procedures. When the request is denied, notifications are made to the member and provider with an explanation of the reason of the decision, a description of the criteria or guidelines used and clinical reason for the decision regarding medical necessity denials. Any written communication to a physician or other health care provider of a denial, delay or modification of a request includes the name of the deciding Medical Director or CMO along with contact information. Information on how to file a grievance or appeal is included.

III. Responsibilities

Health Services follows the Second Opinion policy and procedure as directed, works collaboratively with internal and external departments including Quality, Benefits, IT, Providers and community services.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title 01/18/2017	Title 01/18/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**InterRater Reliability**	**Policy No.:**	HS.09.01
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To standardize Santa Clara Family Health Plan (SCFHP) InterRater Reliability (IRR) testing. The plan's intent is that UM staff demonstrates accurate and consistent application of medical necessity criteria and guidelines.

II. Policy

SCFHP evaluates the consistency with which clinical and non-clinical staff involved with any level of applying UM criteria in decision making at least bi-annually. When a staff member is found to be not proficient, corrective measures are pursued.

I. Medical/Behavioral Health/Pharmaceutical Cases
   1. At least 10 hypothetical cases are presented:
      a. Approved and denied Prior Authorization requests
      b. Requiring non-clinician and/or clinician review
      c. Outpatient and Inpatient services
   2. Reviewers will include all temp, interim, and permanent UM staff and Health Services staff that are involved in prior authorization decision making: care coordinators, personal care coordinators and licensed nurses, pharmacists and medical directors.

II. Review
   1. Identical cases are distributed to each reviewer
   2. The reviewer completes the review individually as if it was a real time review, documenting on paper worksheet
   3. Reviewers must complete cases within 3 business days from receipt.
   4. All cases will be reviewed as a group for a consensus decision-making within 1 week following due date.
   5. Each item is worth one point.
   6. 80% is considered a passing score.
      a. Below Proficient (<80%)
         i. A corrective action plan will be implemented by UM Management. The plan includes the following.
            a) Oversight of employee determinations as appropriate
            b) Training in the area identified to be deficient
            c) Re-testing after training complete to ensure compliance

d) Coaching and observation as appropriate
e) Repeat of process as needed
f) Possible escalation to individualized Performance Improvement Plan which will be part of employee's personnel file.

III. Records

All results and internal Corrective Action Plans (CAPS) remain confidential and are maintained within Health Services and are reported to the QIC.

IV. Policy Reference

N/A

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN	Jeff Robertson, MD
Signature: Sandra Carlson	Signature: Jeff Robertson, MD
Name: Health Services Director	Name: Chief Medical Officer
Title: 01/18/2017	Title: 01/18/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1		Utilization Management	Approve/01/18/2017	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**UM Financial Incentives (Prohibition of)**	**Policy No.:**	HS.10
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To provide clear directives prohibiting financial incentives for Utilization Management decisions.

II. Policy

A. SCFHP does not reward decision makers or other individuals for UM decisions. Providers, practitioners and members are notified of this policy through the Member Handbook and Provider Manual, which are also available on the website.

1. The Plan at no time provides financial or other incentives for UM decisions. UM approvals and denial decisions are based strictly on the appropriateness of care or service and existence of coverage.
2. The Plan never specifically rewards practitioners or other individuals to deny, limit, or discontinue medically necessary covered services.
3. The Plan does not encourage decisions that result in underutilization of care or services.
4. SCFHP Staff and Providers are notified annually of the Plan policy of prohibition for financial or other incentives for UM decisions.

III. Responsibilities

All internal, contracted staff and vendors involved with UM activities are notified of the policy prohibiting financial incentives for UM decisions. IT and Benefits ensure the appropriate criteria/benefits are in place for appropriate decision making. Compliance/QA activities monitor.

IV. References

3 Way Contract. (2014). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A. UM4;Elemement G

Technical Assistance Guide; Utilization Management; Routine Medical Survey UM-001. (2015, October 27). *Department of Managed Healthcare; Division of Plan Surveys*. California, United States: California Department of Health Care Services.

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN	Jeff Robertson, MD
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title 01/18/2017	Title 01/18/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v 1	**Original**	**Utilization Management**	**Approve 01/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Informed Consent	**Policy No.:**	HS.11
Replaces Policy Title (if applicable):	Informed Consent Policy	**Replaces Policy No. (if applicable):**	PPQI-04C
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To standardize Santa Clara Family Health Plan's (SCFHP) provider requirements for obtaining, documenting and storing informed member consent.

II. Policy

SCFHP recognizes that it is necessary for members to be aware of risks and benefits of treatment and options available. It is Plan policy that members be well informed and that consent for certain high risk procedures/services as well as reproductive health services be obtained and properly recorded and stored in the member medical record.

III. Responsibilities

Health Services developed and maintains the policy on Informed Consent. The Utilization Management Committee adopts and reviews the policy. Provider Relations and Marketing provide information to members and providers via the web site. Quality Improvement reviews medical records for necessary documentation.

IV. References

DHCS Renewed Contract; Exhibit A, Attachment 4, Medical Records, 6)
Knox Keene**§ 1363.02.** Reproductive health services information; statement

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title 01/18/2017	Title 01/18/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Preventive Health Guidelines**	**Policy No.:**	HS.12
Replaces Policy Title (if applicable):	Pediatric Preventive Health Services Adult Preventive Health Services	**Replaces Policy No. (if applicable):**	QM003_02 QM004_02
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To standardize Santa Clara Family Health Plan's (SCFHP) Preventive Health Guideline adoption, promotion and management.

II. Policy

SCFHP guidelines are intended it help clinicians, practitioners and members make informed decisions about appropriate preventive health care. This includes guidelines for perinatal care, children up to 24 months, 2-19 years, adults 20-64 years, or 65 or more years old.

The Utilization Management Committee (UMC) reviews and adopts preventive health guidelines that define standards of practice as they pertain to promoting preventive health services. Whenever possible, guidelines are derived from nationally recognized sources. They are based on scientific evidence, professional standards or in the absence of the availability of professional standards, an expert opinion. The preventive health guidelines are reviewed and updated at least every two years and more frequently when updates are released by the issuing entity. The Plan expects its practitioners to utilize the adopted guidelines in their practices, and recognizes the inability of the guidelines to address all individual member circumstances.

III. Responsibilities

The Preventive Health Guidelines are developed by health services utilizing nationally recognized sources The Guidelines are reviewed at least bi-annually... Guidelines are available to providers and members on the Plan website.

IV. References

28 CCR 1300.70(b) (2) (G) (5)
28 CCR 1300.70(b) (2) (H)
NCQAStandardsQI7ElementB

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title 01/18/2017	Title 01/18/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Nurse Advice Line**	**Policy No.:**	HS.13
Replaces Policy Title (if applicable):	Nurse Advice Line	**Replaces Policy No. (if applicable):**	UM 111_01
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To describe Santa Clara Family Health Plan's (SCFHP) Nurse Advice Line services.

II. Policy

SCFHP's Nurse Advice Line is available 24 hours a day, seven days a week with immediate telephonic access to a California Licensed Registered Nurse to assist with a multitude of varying member health care needs. Members have access to support for a broad range of health related questions, including acute and chronic disease triage, education or prevention. Members are advised regarding accessing care and the most appropriate level of care, based on their inquiries. Follow-up with members is arranged as needed, which may include health plan case management services.

Nurse Advice Line services include the use of TDD equipment to handle the needs for deaf/hard of hearing individuals, and also Language Line Interpretation services for member languages other than English.

III. Responsibilities

Multiple departments at SCFHP maintain responsibilities related to the Nurse Advice Line. Health Services and Customer Service provides member follow-up as appropriate. Marketing maintains information regarding the Nurse Advice Line on the Plan web site. Quality Improvement and Delegation Oversight tracks and monitors the Nurse Advice Line for trends, performance and member satisfaction.

IV. References

NCQA 2016

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Medical Management	Name Chief Medical Officer
Title 07/19/2017	Title 07/19/2017
Date	Date

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DRAFT FOR JANUARY 2018 UMC

Santa Clara Family Health Plan

Utilization Management Program Description

2018

Introduction

Santa Clara Family Health Plan (SCFHP) has implemented a Utilization Management (UM) Plan consistent with Medicare regulations, the National Committee for Quality Assurance (NCQA) standards and the California Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) requirements to consistently measure and monitor processes to improve the effectiveness, efficiency, and value of care and services provided to the members of SCFHP. SCFHP has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.

The UM program description is reviewed and approved by the SCFHP Utilization Management Committee (UMC) annually. SCFHP may provide recommendations for Quality Improvement (QI) activities to improve the comprehensive UM program. A SCFHP chief medical officer or medical director is involved in UM activities, including implementation, supervision, oversight and evaluation of the UM Program. To assess the effectiveness of the UM program and to keep UM processes current and appropriate. SCFHP annually evaluates the UM Program for:

- The program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioners in the program.
- Member and provider experience data

Santa Clara Family Health Plan (SCFHP) Background

Santa Clara Family Health Plan (SCFHP) is a local, public, not-for-profit health plan dedicated to improving the health and well-being of the residents of Santa Clara County. Our mission is to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with providers, we act as a bridge between the health care system and those who need coverage. We do this by offering comprehensive, affordable medical, dental and vision coverage through our health insurance programs:

Medi-Cal, Cal MediConnect and Healthy Kids (Medi-Cal is a public insurance program, Cal MediConnect is a program for people with both Medi-Cal and Medicare, and Healthy Kids is a locally funded insurance program).

Since 1997, SCFHP has partnered with providers to deliver high-quality health care to our members. Through dedication to integrity, outstanding service, and care for our community, we work to ensure that everyone in our county can receive the care they need for themselves and for their families. We currently serve over 250,000 residents of Santa Clara County. For the Cal MediConnect Line of Business we serve approximately 9,000 members.

Section I. Program Objectives & Principles

A. The purpose of the SCFHP Utilization Management (UM) Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of the SCFHP. The UM Program addresses the following information about the UM structure:

1. Guides efforts to support continuity and coordination of medical services
2. Defines UM staff members' assigned activities, including the defining of the UM staff that has the authority to deny medical necessity coverage
3. Addresses process for evaluating, approving and revising the UM program and supporting policies and procedures
4. Defines the UM Program's role in the QI Program, including how SCFHP collects UM information and uses it for QI related activities
5. Improve health outcomes
6. Support efforts that are taken to continuously improve the effectiveness and efficiency of healthcare services

B. The SCFHP maintains the following operating principles for the UM Program:

1. UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage
2. Appropriate processes are used to review and approve provision of medically necessary covered services and are based on the SCFHP policies and procedures through established criteria
3. The SCFHP does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service
4. The SCFHP does not encourage UM decisions that result in under-utilization of care by members
5. Members have the right to:
    a) Participate with providers in making decisions about their individual health care
    b) Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
6. The UM program and the utilization review policies and procedures are available to Members and Providers
7. SCFHP policies and procedures shall cover how Contractosr, Subcontractors, or any contracted entity, authorize, modify, or deny health care services via Prior Authorization, concurrent authorization, or retrospective authorization, under the benefits provided by SCFHP
8. SCFHP policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits
9. SCFHP's policies and procedures shall be consistently applied to medical/surgical, mental health, and substance use disorder services and benefits. See Inter Rater Reliability section

10. SCFHP notifies contracting health care Providers, as well as Members and Potential Enrollees upon request, of all services that require Prior Authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.
11. SCFHP conducts all UM activities in accordance with CA Health and Safety Code 1367.01
12. SCFHP conducts their prior authorization requirements and complies with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d)

Section II. Program Structure

A. Program Authority

1. Board of Supervisors and the Board of Directors

The Santa Clara County Board of Supervisors appoints the Board of Directors (BOD) of the SCFHP, a 12-member body representing provider and community partner stakeholders. The BOD is the final decision making authority for all aspects of the SCFHP programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Directors delegates oversight of Quality and Utilization Management functions to the SCFHP Chief Medical Officer (CMO) and the Quality Improvement Committee (QIC) and provides the authority, direction, guidance, and resources to enable SCFHP staff to carry out the Utilization Management Program. Utilization Management oversight is the responsibility of the Utilization Review Committee (UMC). Utilization Management activities are the responsibility of the SCFHP staff under the direction of the Chief Medical Officer.

2. Committee Structure

The Board of Directors appoints and oversees the QIC, which, in turn, provides the authority, direction, guidance, and resources to the Utilization Management Committee (UMC) to enable SCFHP staff to carry out the Quality Improvement and Utilization Management Programs.

SCFHP UMC meets quarterly in accordance with the SCFHP bylaws and more frequently when needed. Committee meeting minutes are maintained summarizing committee activities and decisions, and are signed and dated. The QIC Committee provides oversight, direction and makes recommendations, final approval of the UM Program.

B. UM Committee

1. Composition, roles, goals, meetings, and additional information will be found in the UM Committee Charter.

2. Responsibilities of the UM Committee

a) Develop, maintain, and execute an effective utilization review and management plan (the Plan) to manage the use of hospital resources in a manner that is efficient and cost effective.
b) The Director of Utilization Review shall review the Plan annually and revise it as necessary.
c) Provide oversight for review and utilization of:
   i. Ancillary services
   ii. Medical necessity of admissions
   iii. Extended length of stay and high cost cases
   iv. Cases of non-covered stays
   v. Short stay inpatient stays
   vi. Observation cases.

d) Verify that utilization management functions meet the standards and requirements of all licensing and regulatory agencies, accrediting bodies, third party payers, and external review agencies.
e) Verify that admissions and discharges are appropriate using well defined criteria.
f) Review and analyze data from the hospital-wide best practice/pathway activities, case mix index, denials, appeals/recoveries, and other sources and make recommendations for actions based on the findings.
g) Establish and approve criteria, standards, and norms for pre-admission reviews, continued stay reviews, and assist in continuing modification of such criteria, standards, and norms.
h) Recommend changes in patient care delivery if indicated by analysis of review findings.
i) Promote the delivery of quality patient care, according to criteria set by the Medical Staff, in an efficient and cost-effective manner.
j) Refer quality concerns identified during the review process to the Enterprise Director of Quality and Patient Safety and/or Risk Management for evaluation and action.

Promote the delivery of quality patient care, according to criteria set by the medical staff, in an efficient and cost-effective manner.

3. Conflict of Interest

No person who holds a direct financial interest in an affiliated health care entity is eligible for appointment to the Utilization Management Committee. For purposes of this policy, SCFHP does not consider employment by the Plan to constitute a direct financial interest in an affiliated entity. No committee member may participate in the review of a case in which either he or she or any of his or her professional associates have been professionally involved, except to provide additional information as requested. Refer to policy and procedure # QI.01 Conflict of Interest.

C. The Quality Improvement Committee

1. Functional responsibilities for the UM Program
   a) Annual review, revision and approval of the UM Program Description
   b) Oversight and monitoring of the UM Program, including:
   c) Review and approval of the sources of medical necessity criteria
   d) Recommend policy decisions
   e) Monitor for over and under-utilization of health services
   f) Design and implement interventions to address over and under-utilization of health services
   g) Guide studies and improvement activities
   h) Oversight of annual program evaluation and review
   i) Review results of improvement activities, HEDIS measures, other studies and profiles and recommend necessary actions

D. Health Services Department

The Health Services Department at the SCFHP is responsible for coordination of programs including the UM Program. The Utilization Management Department staff administer the UM Program. Non-clinical staff may receive and log utilization review requests in order to ensure adequate information is present. Some utilization requests are automatically approved by the care coordinator (non-clinical staff). Appropriately qualified and trained clinical staff uses evidenced based criteria or generally accepted medical compendia and professional practice guidelines to conduct utilization reviews and make UM determinations relevant to their positions (potential denials are referred to licensed physician and pharmacist reviewers). The CMO and Medical Director, conduct reviews that require additional clinical interpretation or are potential denials. The medical directors apply medical necessity criteria that are reviewed and adopted on an annual basis. The CMO or qualified designee is the only staff that makes medical necessity and coverage denial decisions.

1. Communication Services

The UM Staff shall provide the following communication services for members and practitioners:

a) UM personnel are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. The UM Department normal business hours are Monday through Friday, 8:30am to 5:00pm pacific time zone
b) Telephone lines are staffed with professionals who have access to most information/resources needed to provide a timely response. Callers have the option of leaving a voice mail message either during or after business hours
c) UM staff can receive inbound communication regarding UM issues after normal business hours. These calls are returned promptly the same or next business day. Staff is also a resource for other Plan Departments for UM and Case Management questions
d) UM staff are identified by name, title and organization name when initiating or returning calls regarding UM issues
e) The Department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Language assistance/interpretation is also available for members to discuss UM issues
f) Language assistance for members to discuss UM issues is available at no cost to the member
g) SCFHP provides members with 24 hour access to the Nurse Advice Line for information regarding wellness/prevention and to assist members with the following:
    1. Determine whether to seek care
    2. Determine the most appropriate level of care for their condition
    3. Obtain answers to questions about medication
    4. Obtain information about providers
    5. Obtain information about non-urgent illnesses or injuries
    6. Apply self-care prior to a health care visit
    7. Receive bi-lingual or translation services

2. Roles / UM Staff Assigned Activities

a) Chief Medical Officer (CMO)

The Chief Medical Officer is a physician who holds an active, unrestricted California license and is designated with responsibility for development, oversight and implementation of the UM Program. The CMO serves as the chair of the QIC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOD. The CMO works collaboratively with SCFHP community partners to continuously improve the services that the UM Program provides to members and providers. The CMO is the senior level physician for medical determinations and his/her role includes:

- Setting UM medical policies
- Supervising operations
- Reviewing UM cases
- Participating in UMC
- Evaluation of the UM program

b) Medical Directors

The Medical Directors are licensed physicians with authority and responsibility for providing professional judgment and decision making regarding matters of UM. Medical Director responsibilities include, but are not limited to, the following:

1. Support processes where medical decisions are rendered by, and are not influenced by fiscal or administrative management considerations. The decision to deny services based on medical necessity is made only by Medical Directors
2. Ensure that the medical care provided meets the standards of practice and care
3. Ensure that medical protocols and rules of conduct for plan medical personnel are followed
4. Develop and implement medical policy.
5. A medical director is designated to be involved with UM activities, including implementation, supervision, oversight and evaluation of the UM program
6. Any changes in the status of the CMO or Medical Directors shall be reported to Department of Health Care Services (DHCS) within ten calendar working days of the change.
7. The SCFHP may also use external specialized physicians to assist with providing specific expertise in conducting reviews. These physicians hold current, unrestricted licenses in the state of California and are board certification by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in specific areas of medical expertise. The CMO is responsible for managing access and use of the panel organization of specialized physicians. An example of external specialist physicians

would be psychiatry or psychology for making determinations regarding mental health care.

c) Health Services Director and UM Manager

The Health Services Utilization Manager is responsible for the day to day management of the UM department, the overall UM Department operations and for coordination of services between departments. These responsibilities include:

1. Develop and maintain the UM Program in collaboration with the Medical Director and Health Services Managers including Behavioral Health Manager(s) and Long Term Support Services(LTSS) Management staff
2. Coordinate UM activities with the Quality Department and other SCFHP units.
3. Maintain compliance with the regulatory standards.
4. Monitor utilization data for over and underutilization.
5. Coordinate interventions with the Health Services Medical Director and staff to address under and over utilization concerns when appropriate.
6. Monitor utilization data and activities for clinical and utilization studies.
7. Maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans and community partners, sharing information about requirements and successful evaluation strategies
8. Implement a yearly UM program evaluation and member and provider satisfaction surveys

d) UM Lead Coordinator

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Responsible for the daily operational management of the Utilization Management Department activities, such as: authorization processing, letter creation, provider outreach and education and supervising staff productivity, training and development., daily supervision of non-clinical Utilization Care Coordination and data entry staff.

e) Pharmacy Director

The Pharmacy Director, or designee, is a licensed pharmacist (Pharm. D.) responsible for coordinating daily operations, and revewing and managing pharmacy utilization reports to identify trends and patterns. The Director provides clinical expertise relative to the Pharmacy, Quality, and Utilization Management components of SCFHP plan management, including Member and Provider Services, and Claims operations. The scope of responsibilities of the Pharmacy Services Director includes:

1. Render pharmaceutical service decisions (approve, defer, modify or deny) pursuant to criteria established for the specific line of business by the CMO and the SCFHP Pharmacy and Therapeutics Committee or generally accepted medical compendia and professional practice guidelines
2. Assure that the SCFHP maintains a sound pharmacy benefits program.
3. Manage the SCFHP Medication Formulary on an ongoing basis
4. Manage the Drug Utilization Review program
5. Monitor compliance with delegation requirements and the performance of the Pharmacy Benefits Management firm's services
6. Provide clinical expertise and advice for the on-going development of pharmacy benefits.
7. Review medication utilization reports to identify trends and patterns in medication utilization
8. Develop and manage provider and client education programs to improve medication prescribing patterns and to increase patient compliance
9. Ensure compliance with Federal and State regulatory agencies
10. Manage the contract with, and delegated activities of, the pharmacy benefits management organization

f) Utilization Review and Discharge Planning Nurses

Licensed, Registered nurses are responsible for the review and determinations of medical necessity coverage decisions. Nurses may provide prospective, concurrent and retrospective inpatient or outpatient medical necessity coverage determinations using established and approved medical criteria, tools and references as well as their own clinical training and education. Utilization Review Nurses also work collaboratively with case managers and assist with member discharge planning. All cases that do not satisfy medical necessity guidelines for approval are referred to a Medical Director for final determination. The CMO or Medical Directors are available to the nurses for consultation and to make medical necessity denials.

g) Nurse Case Managers

Case management services at the SCFHP are licensed registered nurses responsible for the case management for selected members with complex medical conditions. Case managers, in collaboration with the treatment team and with family members when appropriate, coordinate and facilitate the provision of appropriate medical services and available resources to meet the member's individual needs and promote quality, cost-effective outcomes. Please refer to the Case Management Program for additional information. The scope of responsibilities of Nurse Case Mangers includes:

1. Assists members, providers and facilities with transitions of care
2. Identifies targeted behaviors and assists participant members in moving through stages of change.

3. Reviews participant's functional status, formal and informal family support system, determining participant's desired outcome of care and needs for participant education
4. Develops and facilitates implementation of a care plan addressing the total healthcare needs of the participants. This is the Interdisciplinary Care Plan (ICP)
5. Identifies participant barriers to accessing health care services
6. Functions as part of the multi-disciplinary treatment team, facilitating communications with primary managing physician and other members of the condition management team. Initiates the Interdisciplinary Care Team (ICT) process with the member, primary care physician, and others at the request of the member

h) Non-Clinical Staff

Non-clinical staff in multiple roles perform a variety of basic administrative and operational functions. Clinical staff provides oversight to the non-clinical staff.
Roles and responsibilities include:

1. Care Coordinators process selected approvals that do not require clinical interpretation, and complete intake functions with the use of established scripted guidelines.
2. Health Services Administrative Assistant assists with mailings and data collection

i) Behavioral Health Staff Assigned Activities

1. Medical Director or CMO
   i. Reviews denials, changes in requested service.
      a) If there is a change in the authorization request for a behavioral health related inpatient or partial hospitalization stay for a member, this is considered a denial. The denial will be reviewed by the SCFHP MD or CMO who shall consult with a SCFHP psychiatrist as needed.
   ii. Involved in the implementation of the behavioral health care aspects of the UM Program
   iii. Establishes UM policies and procedures relating to behavioral healthcare
   iv. Reviews and decides UM behavioral healthcare cases
   v. Participates in UM Committee meetings

2. Psychiatrist
   i. SCFHP contracts with a board certified psychiatrist to provide consultation and participation in the following
   ii. Implementation of the behavioral health care aspects of the UM Program
   iii. Establishing UM policies and procedures related to behavioral healthcare

iv. Participates in UM Committee meetings
v. Development and approval of behavioral health criteria
vi. Review and decides UM behavioral healthcare cases
vii. Oversight of UM referrals and cases

3. Behavioral Health Director
   i. The BH Director is a BH clinician and has responsibility to facilitate the review of all referrals to the BH department for appropriate triage and assignment. The priority for assignment will be for psychiatrically hospitalized members, frequent emergency room (medical and psychiatric ER), emergent or urgent situations of a life-threatening nature, care coordination with Specialty Mental Health members. All other referrals from internal and external sources will be prioritized as staff time is available.
   ii. The BH Director is responsible to oversee Quality Improvement monitoring to continuously assess application of utilization management criteria, turn-around-times, appropriate level of care, etc. The Director Drives compliance with behavioral health related HEDIS measures to support member access to preventive services and management of chronic conditions.

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4. Behavioral Health Case Manager (s)
   i. The BH case manager will review all psychiatric hospitalizations and partial hospitalizations for medical necessity and to provide coordination of care upon discharge. The BH case manager will contact the hospital case manager to ensure that a plan is developed for aftercare. If the hospitalization is reviewed retrospectively, the BH case manager will contact the member or member's parents to arrange for coordination of aftercare. The BH case manager will work to ensure that members receive follow-up care by a behavioral health practitioner within 30 days following a hospital discharge.

j) Pharmacy Staff

SCFHP staff is composed of clinical pharmacists, pharmacy technicians and a medical director. The Plan staff roles and responsibilities include but are not limited to:

i. Review of all prior authorization requests for non-formulary medication therapy
ii. Review of all pharmacy appeals
iii. Delegation oversight of the Pharmacy Benefit Manager
iv. Quality Improvement monitoring to continuously assess application of criteria, turn-around-times, step therapy, etc.
v. Provides education to the contracted network staff as necessary

vi. Drives compliance with medication related HEDIS measures to support member access to preventive services and management of chronic conditions

E. UM Program Evaluation / Process for evaluating, approving and revising the UM program and the staff responsible for each step

1. Annual Evaluation

Members of the UM Program management team (CMO, Medical Director, UM and BH Director and Director of UM operational areas) annually evaluate and update the UM Program and develop the Annual UM program evaluation to ensure the overall effectiveness of UM Program objectives, structure, scope and processes. The evaluation includes, at a minimum:

a) Review of changes in staffing, reorganization, structure or scope of the program
b) Analysis of annual aggregated data related to UM processes and activities
c) Resources allocated to support the program
d) Review of completed and ongoing UM work plan activities
e) Assessment of performance indicators
f) Review of delegated arrangements activities
g) Recommendations for program revisions and modifications

The UM management team presents a written program description and program evaluation to the UMC which is then taken to QIC. The QIC reviews and approves the UM Program description and evaluation on an annual basis. The review and revision of the program may be conducted more frequently as deemed appropriate by the QIC, CMO, CEO, or BOD.

The QIC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOD and submitted to DHCS, CMS on an annual basis.

F. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Director of Compliance with the oversight of the QIC. Performance results are analyzed and reviewed with opportunities for improvement identified for intervention and performance management.

1. Quality Improvement UM Program activities:

a. HEDIS measurement and reporting
b. Under and Over Utilization monitoring as exampled by:
    1. Readmission rates
    2. Access to preventive health services
    3. Bed days
    4. Length of Stay
c. Appeal, denial, deferral, modification and grievance monitoring
d. Provider profile measurement
e. Potential quality issue referrals

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f. Quality Improvement Work Plan indicators
g. Quality improvement projects
h. Inter-rater reliability assessments
i. Focused ad hoc analyses
j. Regulatory compliance
k. Delegation oversight
l. Member and provider satisfaction with the UM process
m. Member and provider education
n. Member notifications for denial reason
o. UM Turn-around-times
p. Nurse Advice Line utilization and trends
q. Monitoring of groups with shared savings/capitation agreements
    1. SCFHP monitors groups with CAP agreements for under-utilization so that members receive optimal care regardless of risk agreement with provider group or plans.

2. UM Data Sources

Sources are used for quality monitoring and improvement activities, including those both directly administered by SCFHP and their delegates

a. Claims and encounter data
b. Medical records
c. Medical utilization data
d. Behavioral Health utilization data
e. Pharmacy utilization data
f. Appeal, denial, and grievance information
g. Internally developed data and reports
h. Audit findings
i. Other clinical or administrative data

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports are reviewed. Reports are structured so that they are available on a patient specific, provider or group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting system allows for focused problem identification and resolution.

SCFHP's Pharmacy Benefit Coordinator routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. Pharmacy utilization is also monitored by individual physicians and across practice and provider sites. Appropriate clinical interventions and/or other strategies are implemented when required and monitored for effectiveness.

3. Utilization Management Performance Monitoring

a. Areas to monitor

The Director of Medical Management monitors the consistency of the UM staff in handling approval, denial and inpatient decisions. Turnaround time of UM decisions, including verbal and written notification is also monitored. CMO and Medical Director decisions are periodically reviewed by a physician for consistency of medical appropriateness determinations. Telephone service, as related to the percentage of calls that go into the hold queue, abandonment rate and average speed of answer is tracked. Additional monitoring of the Utilization Management Program is performed through comments from the Member Satisfaction Survey, the Physician and Office Manager Satisfaction Survey, Case Management Member Satisfaction Survey, and the quarterly appeals reports Product-line specific, high level, summary cost and utilization data is reviewed and analyzed monthly but not limited to the following areas:

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1. Discharges/1,000
2. Percentage of members receiving any mental health service
3. Hospital outpatient services/1,000
4. ED visits/1,000 (not resulting in admission)
5. Primary Care visits/1,000
6. Specialty Care visits/1,000
7. Prescription Drug services
8. Denials
9. Deferrals
10. Modifications
11. Appeals

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports are reviewed. Reports are structured so that they are available on a patient specific, provider or group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting system allows for focused problem identification and resolution.

The Plan's Pharmacy Benefit Manager routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. Pharmacy utilization is also monitored by individual physicians and across practice and provider sites. Appropriate clinical interventions and/or other strategies are implemented when required and monitored for effectiveness.

b. Access to UM Staff

Utilization and Case Management staff is available Monday through Friday (excluding holidays) from 8:30 a.m. to 5:00 p.m. to answer questions regarding UM decisions, authorization of care and the UM program. The Department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Language assistance/interpretation is also available for

members free of charge to discuss UM issues. Telephone lines are staffed with professionals who have access to most information/resources needed to provide a timely response. Callers have the option of leaving a voice mail message either during or after business hours. These calls are returned promptly the same or next business day. Staff is also a resource for other Plan Departments for UM and Case Management questions.

G. Appeal Procedures

The SCFHP maintains procedures by which a member, authorized representative and provider can appeal a UM organization determination that results in a denial, termination, or limitation of a covered service. The UM Program procedure for appeals includes provisions for timely and appropriate notification of pre-service, post-service and expedited appeals along with an option for external level review. Appeals are administered in accordance with SCFHP policies and procedures, and regulatory standards.

Detailed information about SCFHP appeal policies and procedures are housed within the appeal and grievance committee and unit.

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MED-UM-0037 – HS.01.XX¶
MED-CGR-0001 through MED-CGR-0011 - Member Grievance and Appeals¶

H. Delegation of Utilization Management Activities

When SCFHP delegates Utilization Management decisions or other UM related activities, the contractual agreements between the SCFHP and this delegated group specify the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the SCFHP, how performance is evaluated; and corrective action plan expectations, if applicable. The SCFHP conducts a pre-contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The SCFHP's Delegation Oversight Manager is responsible for the oversight of delegated activities. Delegate work plans, reports, and evaluations are reviewed by the SCFHP and the findings are summarized at QIC meetings, as appropriate. The Delegated Oversight Manager monitors all delegated functions of each of our delegates through reports and regular oversight audits. The QIC annually reviews and approves all delegate UM programs. Depending on the delegated functions the audit may include aspects of the following areas: utilization management, credentialing, grievance and appeals, quality improvement and claims.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements.
- Provide encounter information and access to medical and behavioral health records pertaining to SCFHP members.
- Provide a representative to the QIC.
- Submit quarterly reports, annual evaluations, and work plans.
- Cooperate with annual audits and complete any corrective action judged necessary by the SCFHP.

SCFHP does not delegate the management of complaints, grievances and appeals. SCFHP conducts a pre-delegation review to measure resources of the potential delegate

Section III. Program Scope, Processes & Information Sources

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members, and include medical necessity determinations regarding the appropriateness of health care services in accordance with definitions contained in the member certificate of coverage. The UM Program also encompasses delegated utilization management functions, activities, and processes for behavioral health and pharmacy services.

A. Clinical Review Criteria

The Utilization Management Program is conducted under the administrative and clinical direction of the Chief Medical Officer and UM Committee. Therefore, it is SCFHP's policy that all medical appropriateness and necessity criteria are developed, and approved by the physician entities prior to implementation. Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the Utilization Management Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised annually that criteria are available upon request, by mail, fax, or email. Internally developed criteria and a general list of services that require prior authorization are also available on SCFHP's web site. MCG® criteria are available to providers upon request with the UM Department. The individual needs of the member and the resources available within the local delivery system are considered when applying Utilization Management criteria.

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1. Adoption of criteria

When adopting Medical Necessity Criteria, SCFHP (with direct oversight by the Chief Medical Officer) will:

a. Have written UM decision-making criteria that are objective and based on medical evidence. The criteria include medical, long term services and support (LTSS), and behavioral healthcare services requiring review.

b. Have written policies for applying the criteria based on individual needs. SCFHP considers the clinical variables for review including:

   a. Age
   b. Comorbities
   c. Complications
   d. Treatment progress
   e. Psychosocial factors
   f. Home environment: when applicable

c. Have written policies for applying the criteria based on an assessment of the local delivery system. The medical, behavioral health, and LTSS units evaluate the local delivery systems in meeting member's needs.

d. Involve appropriate practitioners in developing, adopting and reviewing criteria via the practitioner involvement in UMC.

e. Annually review the UM criteria and the procedures for applying them, and updates the criteria when appropriate. SCFHP reviews UM criteria against current clinical and medical evidence and updates them when appropriate.

2. **Hierarchy of criteria**

Utilization review determinations are derived from a consistently applied, systematic evaluation of utilization management decision criteria. The criteria are selected based on nationally recognized and evidence-based standards of practice for medical services and are applied on an individual needs basis. Primary criteria used for utilization review decisions are from Local Coverage Determinations (LCD); Noridian and National Coverage Determinations (NCD);MCG. A hierarchy of criteria for UM decision is used as outlined by Procedure HS.02.01 – Application of clinical Criteria.

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B. MCG Guidelines (Milliman)¶
C. SCFHP UM approved policies¶
D. Consensus statements and nationally recognized standards of practice (if no other guidelines available)

Deleted: A. Noridian Medicare Portal¶
B. Local Coverage Determinations (Medicare Coverage Data Base, 2016)¶
C. National Coverage Determinations¶
D. MCG Guidelines (Milliman)¶
E. Consensus statements and nationally recognized standards of practice (if no other guidelines available)

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B. MCG Guidelines (Milliman)¶

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C. MCG Guidelines (Milliman)

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B. MCG Guidelines (Milliman)¶
C. Nationally recognized standards of practice (if no other guidelines available)

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C. MCG Guidelines (Milliman)¶
D. Consensus statements and nationally recognized standards of practice (if no other guidelines available)

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B. MCG Guidelines (Milliman)¶
C. Nationally recognized standards of practice (if no other guidelines available)

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C. Micromedex¶
D. Consensus statements and nationally recognized standards of practice (if no other guidelines available)

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Investigative or Experimental Medication¶

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B. MCG Guidelines (Milliman)¶
C. Nationally recognized standards of practice (if no other guidelines available)

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B. Appointed special work group composed of the Medical Director and Board Certified specialists specific to the need of the request¶
C. Reviewed through the P&T Committee or appointed special work group to assess

Other applicable publicly available clinical guidelines from recognized medical authorities are referenced, when indicated. Also when applicable, government manuals, statutes, and laws are referenced in the medical necessity decision making process. The QIC annually reviews the Care Guidelines and criteria and applicable government and clinical guidelines for changes and updates.

Additionally, the SCFHP has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in benefit plans in order to keep pace with changes and to ensure that members have equitable access to safe and effective care.

B. Medical Necessity

The Utilization Management Program is conducted under the administrative and clinical direction of the Chief Medical Officer and the Utilization Management Committee.
Therefore, it is the policy of SCFHP that all medical appropriateness/necessity criteria are developed, reviewed and approved by the physician entities prior to implementation.

Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the Utilization Management Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised annually that criteria are available upon request. Internally developed criteria and a general list of services that require prior authorization are also available on the web site for SCFHP.

Specific MCG criteria are available to providers by contacting the UM Department or the physician reviewer. The individual needs of the member and the resources available within the local delivery system are considered when applying Utilization Management criteria.

Members may request a copy of the medical necessity criteria. When the disclosure of UM criteria is made to the public, the disclosure will be accompanied by the following notice:

> "The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

The Medicare Model Explanation of Coverage (EOC) defines medically necessary services or supplies as those that are:" 1) Proper and needed for the diagnosis or treatment of your medical condition; 2) Used for the diagnosis, direct care, and treatment of your medical condition; 3) Not mainly for your convenience or that of your doctor; and those that 4) Meet the standards of good medical practice in the local community."

1. Medical Necessity Determinations

Medical necessity determinations are made based on information gathered from many sources. Each case is different. However, these sources may include some or all of the following:

a) Primary Care Physician
b) Specialist physician
c) Hospital Utilization Review Department
d) Patient chart
e) Home health care agency
f) Skilled nursing facility
g) Physical, occupational or speech therapist
h) Behavioral health/chemical dependency provider
i) Patient or responsible family member

The information needed will often include the following:

a) Patient name, ID#, age, gender
b) Brief medical history
c) Diagnosis, co morbidities, complications
d) Signs and symptoms
e) Progress of current treatment, including results of pertinent testing
f) Providers involved with care
g) Proposed services
h) Referring physician's expectations
i) Psychosocial factors, home environment

The Utilization Review Nurses will use this information, along with good nursing judgment, departmental policies and procedures, needs of the individual member and characteristics of

the local delivery system, including the availability of the proposed services within the network service area, or case conference discussions with a SCFHP Medical Director, to make a decision.

If the decision is outside the scope of the Utilization Review Nurse's authority, the case is referred to the Medical Director for a determination. The Medical Director or Pharmacists or designated behavioral health practitioner as appropriate, are the only Plan representatives with the authority to deny payment for services based on medical necessity/appropriateness. Psychiatrists, doctoral-level clinical psychologists, or certified addiction medicine specialists have the authority to deny payment for behavioral health care services based on medical necessity and appropriateness. Alternatives for denied care or services are given to the requesting provider and member and are based on the criteria set used or individual case circumstances. In making determinations based on contract benefit exclusions or limitations, the Member Handbook and Group Services Agreement are used as references.

2. Inter-Rater Reliability

The Referral Management Manager monitors the consistency of the UM/MH/MLTSS/Pharmacy staff staff inhandling approval, denial and inpatient decisions. The Inter-Rater Reliability (IRR) testing process evaluates consistent application amongst the Utilization Management (UM) teams (UM, BH, MLTSS, pharmacy staff), including all staff who apply medical necessity criteria, including medical directors, registered and licensed nursing staff, pharmacists, pharmacy technicians, non-clinical staff. Please refer to IRR Policy HS.09.01.

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All staff is assessed through the established IRR process at least annually. All new hires are reviewed monthly for the first 90 days and then again annually.

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C. Timeliness of UM Decisions

SCFHP maintains a policy and procedure (P&P) meeting state, federal, and NCQA (National Committee for Quality Assurance)regulations/guidelines for meeting timeliness standards of UM decisions and notification. The P&P is comprehensive and includes non-behavioral and behavioral UM decision/notification timeframes, it is reviewed/revised at least annually. The operations dashboard is updated monthly and staff is monitored and evaluated on meeting timeliness standards.

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D. Clinical Information

When determining coverage based on medical necessity for non-behavioral, behavioral, and pharmacy decisions,, SCFHP obtains relevant clinical information and consults with the treating practitioner where necessary. The reviewing medical director or pharmacist shall document any consults conducted and will acknowledge the clinical information considered when making a decision to deny, delay or modify a request for service or care.

Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.

- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.
- Behavioral Health Assessment

E. Transplants

It is SCFHP's policy that all requests for organ transplants be reviewed by the Medical Director and Case Manager and the members are directed to the most appropriate Center of Excellence transplant facility for evaluation based on benefits. The Case Manager coordinates with the facility transplant coordinator to send the transplant recommendation to SCFHP, as appropriate, prior to approval by the Plan. Renal and corneal transplants are excluded from SCFHP review. The Plan's determination of medical necessity will be based on the Transplant Team determination, thus providing an outside, impartial, expert evaluation. Once the member has been approved, the member is enrolled in the United Network for Organ Sharing (UNOS). The patient's acceptance into UNOS serves as the Plan's medical necessity determination. All members that are approved for transplant are followed closely by Case Management as well as Paramount's interdepartmental transplant team, consisting of Medical Directors, Case Managers and Financial, Claims and Actuarial representatives. The purpose of the team is to ensure ongoing medical necessity for transplant, employer group high dollar alert (if self-insured), and reinsurance notification and to ensure appropriate claims payment.

F. New Technology Assessment

SCFHP investigates all requests for new technology or a new application of existing technology using the HAYES Medical Technology Directory® as a guideline to determine whether the new technology is investigational in nature. If further information is needed, the Plan utilizes additional sources, including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. Pharmaceuticals are investigated by the Pharmacy and Therapeutics Working Group. If the new technology, pharmaceutical or new application of an existing technology or pharmaceutical is addressed in the above documents, the information is taken into consideration by the Medical Director at the time of benefit determination.

If the new technology, pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director will confer with an appropriate board certified specialist consultant for additional information. This information will be presented to the Technology Assessment or Pharmacy and Therapeutics Committee, subcommittees of the Medical Advisory Council, to provide a recommendation to the physician Council regarding coverage. The decision will be based on safety, efficacy, cost and availability of information in published literature regarding controlled clinical trials. If a decision cannot be made, a committee of specialists (including medical, pharmacy, and behavioral health practitioners) may be convened to review the new medical technology/pharmaceutical and make a recommendation to the Medical Advisory Council.

G. Emergency Services/Post Stabilization Care

No referrals are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy
b. Serious impairment to bodily functions
c. Serious dysfunction of any bodily organ or part.

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.

SCFHP properly arranges for the transfer of members after the member has been stabilized subsequent to an emergency psychiatric or medical condition but the provider believes further medically necessary health care treatment is required and the member cannot be safely discharged.

SCFHP does not require prior authorization for post-stabilization care

- The Plan shall fully document all requests for authorizations and responses to such requests for post stabilization medically necessary care which shall include the date and time of receipt, the name of the health care practitioner making the request and the name of the SCFHP representative responding to the request. All non-contracting hospitals are able to locate a

contact number at which the hospital can obtain authorization from the SCFHP by the information on the back of the member's identification card or by the website of the Plan

- SCFHP has mechanisms in place to support that a patient is not transferred to a contracting facility unless the provider determines no material deterioration of the patient is likely to occur upon transfer

H. Determination Information Sources

UM personnel collect relevant clinical information from health care providers to make prospective, concurrent and retrospective utilization review for medical necessity and health plan benefit coverage determinations. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to make medical necessity and health plan benefit coverage determinations include the following:

1. History and physical examinations
2. Clinical examinations
3. Treatment plans and progress notes
4. Diagnostic and laboratory testing results
5. Consultations and evaluations from other practitioners or providers
6. Office and hospital records
7. Physical therapy notes
8. Telephonic and fax reviews from inpatient facilities
9. Information regarding benefits for services or procedures
10. Information regarding the local delivery system
11. Patient characteristics and information
12. Information from responsible family members

I. Health Services

The scope of health services and activities includes utilization review determinations, referral management, discharge planning, complex case management, and UM documents.

1. Utilization Determinations

Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria. Qualified health care professionals supervise utilization review decisions of assigned UM staff and participate or lead UM staff training. These professionals also monitors all UM staff for consistent application of UM criteria for each level and type of UM decision, monitors all documentation for adequacy and is available to UM staff on site or by telephone. Under the supervision of a licensed medical professional, non-clinical staff collects administrative data or structured clinical data to administratively authorize cases that do not require clinical review.

Only a Medical Director, with a current California license to practice without restriction, makes medical necessity denial determinations. A Medical Director (medical or behavioral health) and/or an

appropriately licensed pharmacist is available to discuss UM denial determinations with providers, and providers are notified about determination processes in the denial letter.

When applying medical necessity criteria, SCFHP shall

a. Consider individual needs of members
    i. Age
    ii. Comorbidities
    iii. Complications
    iv. Progress of treatment
    v. Psychosocial situation
    vi. Home environment, as applicable
b. Assessment of the local delivery system
    i. Availability of inpatient outpatient and transitional facilities
    ii. Availability of outpatient services in lieu of inpatient services such as surgi-centers vs. inpatient surgery
    iii. Availability of highly specialized services, such as transplant facilities or cancer centers
    iv. Availability of skilled nursing facilities, sub acute care facilities or home care in the organization's service area to support the patient after hospital discharge
    v. Local hospitals' ability to provide all recommended services within the estimated length of stay

In accordance with the DHCS contract only qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made on the basis of medical necessity. Additionally, a qualified physician or pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan medical director, in collaboration with the Plan Pharmacy and Therapeutics Committee (PTC) or generally accepted medical compendia and professional practice guidelines.

UM decisions are not based on the outcome of individual authorization decisions or the number and type of non-authorization decisions rendered. UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. UM staff involved in clinical and health plan benefit coverage determination process are compensated solely based on overall performance and contracted salary, and are not financially incentivized by the SCFHP based on the outcome of clinical determination.

Board certified physician advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

For each non-medical necessity denial, the UM Department documents within it's UM system the reason for and the specific benefit provision, administrative procedure or regulatory limitation used to

classify the denial. The UM staff references the sources (e.g. Certificate of Coverage or Summary of Benefits) of the administrative denial. The Plan includes this information in the denial notice sent to the member or the member's authorized representative and the practitioner.

Decisions affecting care are communicated in writing to the provider and member in a timely manner in accordance with regulatory guidelines for timeliness. Notification communication includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member's line of business. Member correspondence about authorization decisions includes a statement in each SCFHP threshold language instructing the member how to obtain correspondence in their preferred language.

The UM Program appeals and reconsideration policies and procedures assure members and providers that the same staff involved in the initial denial determination will not be involved in the review of the appeal or reconsideration. Additionally, there is separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

The UM Program includes the following utilization review processes:

a) Prospective Review

Prospective (pre-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.

b) Concurrent Review

Concurrent review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.

c) Retrospective Review

Retrospective (post-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member. A retrospective review decision is based on the medical information available to the health care provider at the time the service or supply was provided.

d) Standing Referrals

SCFHP has established and implemented a procedure by which a member may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary

care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the member.

e) Terminal Illness

In the circumstance occur where SCFHP denies coverage to member with a terminal illness, which refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, SCFHP shall provide to the member within five business days all of the following information:

1. A statement setting forth the specific medical and scientific reasons for denying coverage
2. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine
3. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the member to request a conference as part of the plan's grievance system

f) Communications

Decisions to approve, modify, or deny requests by practitioners for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting practitioner verbally as appropriate and in writing. See pages 17 through 21 for notification timelines.

In the case of concurrent review, care shall not be discontinued until the member's treating practitioner has been notified of SCFHP's decision and a care Plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

Communications regarding decisions to approve requests by practitioners prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to practitioners initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for SCFHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider to contact the professional responsible for the denial, delay, or modification with ease. Responses shall also include information as to how the member may file a grievance with the Plan.

For non-behavioral, behavioral, and pharmacy communication to members for denial, delay, or modification of all or part of the requested service shall include the following:

a) Be written in a language that is easily understandable by a layperson
b) Specify the specific health care service requested
c) Provide a clear and concise explanation of the reasons for the Plan's decision to deny, delay, or modify health care services. Reason shall be written in layperson terms, easily understandable by the member
d) Specify a description of the criteria or guidelines used for the Plan's decision to deny, delay, or modify health care services
e) Specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services
f) Include information as to how he / she may file a grievance to the Plan
g) Include information as to how he / she may request an independent medical review
h) Include a statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the decision was based , upon request

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g) Referral Management

1. In-network

SCFHP network physicians are the primary care managers for member healthcare services. The network primary care physicians provide network specialist and facility referrals directly to members without administrative pre-authorization from the UM Program, and primary care physicians may coordinate prior authorization for utilization review on a number of services such as DME, home health, and nutritional supplements. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program from claims and encounter data. All elective inpatient surgeries and non-contracted provider referrals require prior authorization. The UM Program care management system tracks all authorized, denied, deferred, and modified service requests and include timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

2. Emergency Services

No referrals or prior authorization requests are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

i. Placing the health of the individual or, with respect to a
ii. pregnant woman, the health of the woman, or her unborn child,
iii. in serious jeopardy
iv. Serious impairment to bodily functions
v. Serious dysfunction of any bodily organ or part

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.

3. Out of Network

Requests for out-of-network Referrals are reviewed individually and determinations are made based on the patient's medical needs and the availability of services within the Provider Network to meet these needs. A physician reviewer shall assess any requests for out of network referrals.

4. Specialist Referrals

The Primary Care Physician (PCP) may request a consultation from a participating specialist physician at any time. No referral is required from SCFHP prior to consultation with any participating specialists.

5. Tertiary Care Services

All referrals to Plan tertiary care centers are reviewed on an individual basis. The member's medical needs and the availability of the requested services within the non-tertiary care network are taken into consideration.

6. Second Opinions

A request for a second opinion may be initiated by a member or a treating healthcare provider of a member, and at no charge to the member. The processing of a request for a second opinion will be treated with the same criteria for turn-around-time as other UM referral requests. If a second opinion is not available within the Member's network, an out-of-network opinion will be arranged, at no cost other than normal co-payments, to the member. The member Evidence of Coverage provides all members with notice of the policy regarding the manner in which a member may receive a second medical opinion. The second opinion policy is reviewed, revised and approved annually.

7. Predetermination of Benefits/Outpatient Certification

Certain procedures, durable medical equipment and injectable medications are prior authorized. SCFHP uses MCG criteria for Imaging, Procedures and Molecular Diagnostics. When MCG criteria does not exist within SCFHP's purchased products, criteria are developed internally by the Technology Assessment Work Group or Pharmacy and Therapeutics Committee as appropriate. Additionally, potentially cosmetic surgery and other procedures may be reviewed prospectively, at the request of providers and members, to issue coverage determinations.

8. Authorization Tracking

SCFHP tracks a defined sub-set of out-patient authorizations for completion of the authorization to claims paid cycle. This allows for monitoring of possible barriers leading to member non-

compliance with prescribed care. In addition, the plan tracks authorizations while in process for timeliness and compliance with regulations and guidelines.

h) Discharge Planning

Discharge planning is a component of the UM process that assesses necessary services and resources available to facilitate member discharge to the appropriate level of care. UM nurses work with facility discharge planners, attending physicians and ancillary service providers to assist in making necessary arrangements for member post-discharge needs. Behavioral health case managers will work with psychiatric hospital facilities to facilitate member discharge to the most appropriate level of care and community case management. Long Term Services and Supports case managers assist members discharging from long term care.

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In accordance with the DHCS contract, primary care physicians provide basic case management services. The SCFHP provides case management for a select number of the Cal MediConnect population and works with a vendor for the majority of the CMC cases. Care is coordinated between the SCFHP and the vendor to ensure collaboration of the multi-disciplinary care team and effective member management. Complex and Intensive case management services assist members to close gaps in care, establish action plans, set clinical condition treatment progress goals, improve medication adherence, and reduce the risk of hospitalization. Complex and case management services also involve opportunities to match the content of medical management to the changing risk levels and needs of individual members. ¶

i) UM Documents

In addition to this program description other additional documents important in communicating UM policies and procedures include:

1. The Provider Manual provides an overview of operational aspects of the relationship between the SCFHP, providers, and members. Information about the SCFHP's UM Program is included in the provider manual. In addition the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.
2. The Provider Manual and the web site also provide information about services/procedures requiring pre-authorization. Changes and updates are communicated to providers via faxed communications, newsletters, bulletins and the website.
3. Provider Bulletin is a monthly newsletter distributed to all contracted provider sites on topics relevant to the provider community and can include UM policies, procedures, and activities.
4. Evidence of Coverage (EOC) documents are distributed to members based on their product line. Members have the right to submit a complaint or grievance about any plan action, and the Evidence of Coverage document directs members to call the Customer Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit

for follow-up response. The SCFHP Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the UM Program information is available on the SCFHP website.

J. Behavioral Health Management

SCFHP provides access to all standard Medicaid based fee-for service benefits, including applicable Behavioral Health services. Behavioral Health utilization management practices are in compliance with parity requirements of Medicaid managed care rules and the Affordable Care Act

SCFHP members receive comprehensive behavioral health and substance abuse services according to their specific benefit package. SCFHP Medi-Cal members obtain mental health and substance use disorder services primarily through the Santa Clara County Behavioral Health Department (CBHD). The Severely Mentally Ill (SMI) population will be referred through the County Call Center to County Behavioral Health Services, Federally Qualified Healthcare Clinics or Community-Based Organizations. The CBHSD will be responsible for payment of services to those who are determined by the CBHD to be SMI. The non-SMI diagnoses will be considered Mild to Moderate and after triage by the County Call Center, will be referred to Network providers by the SCFHP BH department.

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Cal Medi-Connect (CMC) members will be treated the same as Medi-Cal members and referred through the County Call Center. The difference in terms of payment for CMC members is that the professional services for psychiatry, psychology and Licensed Clinical Social Work services are to be billed to SCFHP under the member's Medicare benefit. The Mild to Moderately diagnosed members will be screened by the County Call Center and referred by SCFHP BH department. SCFHP is responsible for payment. Members may contact their County Call Center, or receive physician referral within the member's medical home. SCFHP maintains procedures for primary care providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network.

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Santa Clara Family Health Plan does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.

1. Behavioral Health Integration

The SCFHP uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include

a) A behavioral healthcare practitioner is involved in quarterly HCQC meetings to support, advise and coordinate behavioral healthcare aspects into UM Program policies, procedures and processes.

b) A behavioral healthcare practitioner participates as a member of the UM interdisciplinary care team. The UM interdisciplinary care team consists of a Medical Director, Registered Nurse, Pharmacist and Behavioral Healthcare practitioner. The team meets routinely to perform member case reviews. The interdisciplinary care team evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care, and member's rights and responsibilities.
c) The SCFHP routinely receives clinical reports from Santa Clara County Behavioral Health Services Department, which are reviewed by the Director of Behavioral Health Department.
d) SCFHP participates in quarterly operational meetings with the CBHSD to review and coordinate administrative, clinical and operational activities.

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2. Santa Clara County Behavioral Health Care Services

a) Specialty behavioral health services for Medi-Cal members, excluded from the SCFHP contract with DHCS, are coordinated under a Memorandum of Understanding executed with SCFHP. This is a carve-out arrangement for behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

3. The referral procedure for SCFHP members includes

a) SCFHP Primary Care Providers (PCPs) render outpatient behavioral health services within their scope of practice.
b) PCPs refer the members to Santa Clara County Behavioral Health Services Department for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
c) PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by CBHD.
d) Members may contact the County Call Center to be screened and referred to SCFHP BH department for referrals to Network providers of Mild to Moderate services under Medi-Cal, Cal MediConnect or Healthy Kids coverage

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K. Pharmacy Management

1. Scope

a) SCFHP delegates pharmacy utilization management activities in the Cal MediConnect line of business to the pharmacy benefit management company MedImpact. MedImpact possesses a UM program that manages pharmacy services under the delegated arrangement. Overall UM Program oversight is performed by the Chief Medical Officer or designee with supporting policies and procedures reviewed and approved by the Quality Improvement Committee. The Chief Medical Officer and the Director of Pharmacy (a licensed pharmacist) are responsible for operational and clinical management of the pharmacy UM program. The scope of the UM Program encompasses all processes performed by MedImpact. These processes include: intake and triage services,

authorization guideline development, implementation of UM formulary tools and medication utilization review determinations. The Pharmacy and Therapeutics Committee provides oversight for evidence-based, clinically appropriate UM guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature with consideration for such factors as safety, efficacy and cost effectiveness, and also with the input evaluation of external clinical specialists appropriate to the subject matter. In accordance with state, federal, and NCQA requirements, the pharmacy unit monitors timeliness and maintains policies and procedures on timeliness of UM decisions/notifications for pharmacy. An annual review process and ad hoc assessments support the development of guidelines that are current with the latest advancements in pharmaceutical therapy. The UM Program is evaluated annually and submitted to the Utilization Management Oversight Committee for approval. This evaluation includes, but is not limited to: medication UM activities, UM structure and resources, measures to assess the quality of clinical decisions, overall effectiveness of the UM Program and opportunities for UM Program improvement.

b) Pharmacy Benefit Manager

MedImpact staff, who are delegated to perform pharmacy utilization management services and activities, involve both clinical and administrative personnel. The PBM Staff roles and responsibilities include, but are not limited to:

i. Medical Directors are licensed physicians with oversight of the UM Program, and also provide consultation services.
ii. Clinical Pharmacist Reviewers are licensed pharmacists with responsibility to perform utilization management services.
iii. Prior Authorization Clerks perform administrative functions such as data entry and generating reports.
iv. Prior Authorization Coordinators review medication requests based on MedImpact criteria as approved by SCFHP.
v. Prior Authorization Customer Service Representatives perform intake functions and triage customer inquiries.
vi. Research Coordinators contact provider offices to request additional information to compete a prior authorization request.

L. Long Term Services and Supports

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SCFHP has established and implemented guidelines for Long Term Services and Supports authorizations for services in this area. The LTSS Team including a Long Term Care UM RN and LTSS Case Managers

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coordinates with the UM Department, LTSS providers, and community partners to identify care needs and facilitate access to appropriate services to achieve positive health outcomes.

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M. Confidentiality

SCFHP has written policies and procedures to protect a member's personal health information (PHI). The Health Services Department collects only the information necessary to conduct case management services or certify the admission, procedure or treatment, length of stay, frequency and duration of health care services. We are required by law to protect the privacy of the member's health information. Before any PHI is disclosed, we must have a member's written authorization on file. Within the realm of utilization review and case management, access to a member's health information is restricted to those employees that need to know that information to provide these functions. A full description of SCFHP's Notice of Privacy Practices may be found on our website at: www.scfhp.com.

N. Annual Evaluation

The Health Services Department members: including UM Program management team : including the CMO, Medical Director, UM and BH Manager and Directors of UM operational areas annually evaluate and update the UM Program and develop the Annual UM program evaluation to ensure the overall effectiveness of UM Program objectives, structure, scope and processes. This team is responsible for developing an annual evaluation of the Utilization Management Program to identify strengths and areas for improvement. The written evaluation compares auditing results, utilization reports, quality indicators, survey results, and initiatives and priorities from previous years. Additionally, the Director of Health Services will have processes in place to trigger quarterly reports used for evaluating the efficiency and effectiveness of the Utilization Management Plan throughout the year.

In coordination and collaboration with the UM Medical Director, the Director of Quality Improvement, the UM and QI Committees and the Chief Medical Officer, and Quality Management Committee, the Case Management Department implements identified opportunities for improvement that foster and promote positive change in the case management of SCFHP members. The Director of Case Management is responsible for submitting the department's annual Case Management Plan with incorporated strategies for improvement.

O. Interdepartmental collaboration

SCFHP departments collaborates to prevent conflicting information and to align member self-management tools, member education and information provided to the member.

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

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Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

In meeting the requirements of the SCFHP Utilization Management Program, a Care Coordinator may review a select number of prior authorization requests based upon clinical review criteria set forth in these guidelines and applicable to only these type of services.

Care Coordinators may "approve" covered medical service when criteria are met. The Care Coordinator is responsible to document all pertinent information within the approved authorization. Which includes but is not limited to: Accurately and fully completing authorization entry in QNXT and the Care Coordinator Guideline section and page used to base the approval. All reviews must be completed within the regulatory timeframes for making the determination.

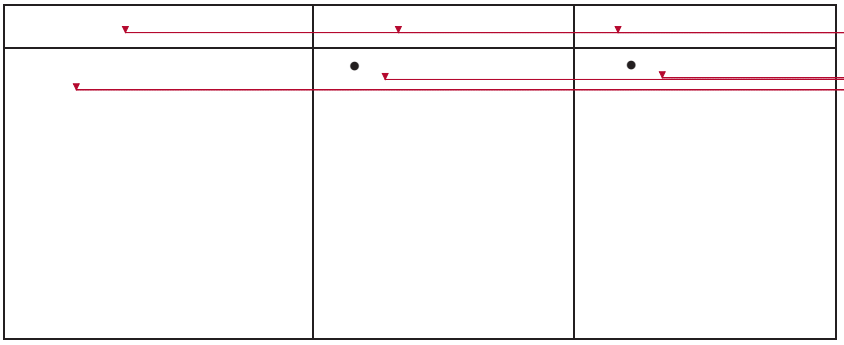
The Care Coordinator **must** refer requests for medical service requiring authorization that do not meet the criteria within these guidelines to a licensed nurse, licensed Behavioral Health clinician or Medical Director within the regulatory timeframes for making the determination.

All Care Coordinator guidelines are reviewed and approved by the SCFHP Utilization Management Committee at least annually.

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Inpatient Acute Hospitalization



Deleted: Healthy Kids

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Authorize 1 day pending nurse review

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<#>Check CCS status (if under 21)¶
Make CCS referral if applicable

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<#>Check CCS status¶
<#>Make CCS referral if applicable¶
<#>Authorize 1 day¶
pending nurse

1. Emergency and observation stay (no inpatient admission)-Does not require Prior Authorization.

2. Inpatient Admission via Emergency room:
   a. Medi-Cal
      - Independent Physician's-Approve 1 day
      - Palo Alto Medical Foundation- MC only (PAMF authorizes for HK)
      - **Out of area emergency admission**-All Networks

        In area emergency admission- VHP, Kaiser, PMG, Premier Care-Redirect to Delegated Group
   b. CMC-All emergency admissions, In area and Out of area approve 1 day
   c. Medi-Cal with Medicare A primary-create authorization and forward to MD for denial for other health provider primary.

3. Inpatient Admission Elective/Scheduled admission: (in area and out of area)
   a. Medi-Cal-Send to Nurse for review if no PA in system
      - Independent Physician's

Utilization Management
Care Coordinator Guidelines

- Palo Alto Medical Foundation- MC only (PAMF authorizes for HK)

  ***Kaiser-Redirect to group

  ***VHP–Send to nurse for review for possible redirection back to network

  ***PMG and Premier care-Send to nurse for review. Possible LOA.

b. Medi-Cal with Medicare A primary-create authorization and forward to MD for denial for other health provider primary.

4. Acute Rehab-send to nurse for review

5. LTAC-Long Term Acute Care-Send to nurse for review

6. Maternity – Approve 2 days for Vaginal delivery, 4 days for C-Section delivery
   a. Approval date starts from the date of baby's birth/date of delivery.
   b. Exceeding days must be send to Nurse for review.
   c. Admission date different from Baby's date of birth must be forwarded to Nurse for review.
   d. Maternity Kick-follow maternity kick entry process for QNXT for Medicare primary without part A, Independent network and for PAMF.

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Skilled Level of Care (SNF)

1. Member must be CMC or Medi-Cal assigned to network:
    a. Independent Physician's
    b. Palo Alto Medical Foundation
    c. VHP, Kaiser, PMG, Premier Care – redirect to Network if within month of admission and month after admission.
    d. SCFHP will be financially responsible beginning 3rd month of admission
    e. Medicare primary
        - Without Medicare A-Apply CCG pre approval of 7 days and forward to nurse review for additional days
        - With Medicare A &B-forward to MD for denial. Medicare is financially responsible for skilled services with exemptions:
            - Skilled days exhausted (100 days per benefit period)

                *SNF must provide NOMNC or proof of exhausted Medicare Skilled Days
2. SNF sends Skilled level of care request to SCFHP UM.
3. Coordinator will approve initial 7 days.
4. Coordinator will forward this request to UM nurse for additional days and concurrent review.

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Long Term Care

1. Member must be CMC or Medi-Cal assigned to network
    a. Independent Physician's
    b. Palo Alto Medical Foundation- MC only
    c. VHP, Kaiser, PMG, Premier Care-redirect to Network if within month of admission and month after admission.

    *** If member is LTC during the time of eligibility, network must be changed to Independent Provider (except for PAMF and Kaiser).

2. SNF sends LTC request (PAR) to SCFHP UM
3. Coordinator will approve initial authorization for 6 months with receipt of complete required LTC PAR documentation from the provider.
4. Any PARs received without required supporting documentation will be voided.
5. Authorization will remain "in process" status and will be assigned to LTC nurse for further review. Send Authorization letter.
6. Nurse may recommend Last Covered Day to MD if LTC criteria is not met.
7. Coordinator will approve 1 year LTC Re-Authorizations with complete LTC PAR documentation and attachments for members that have been in LTC for 2 years or more. These re-authorizations will remain "in process" status and will be assigned to the LTC UM RN for further review. Send re-authorization letter.
8. Re-authorizations for members residing in LTC less than 2 years will be forwarded to nurse for review.

8. All LTC out of area requests will be forwarded to nurse for review for denial as non-covered benefit.

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Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Bed Hold

LTC and Skilled level of care in SNF:

1. Member must be CMC or Medi-Cal assigned to network
    a. Independent Physician's
    b. Palo Alto Medical Foundation- MC only
    c. VHP, Kaiser, PMG, Premier Care redirect to Network if within month of admission and month after admission.
2. Bed Hold Notification Form is received from Facility
3. Coordinator will enter and approve up to 7 days max per Medi-Cal benefit.
    - Separate authorization will be created for Bed Hold.
4. If bed hold request if over 7 days, or if member is out of SNF bed over 7 days, existing LTC or skilled auth will be updated with correct DC date and a new skilled or LTC auth will be created for the days following the bed hold to continue auth for the level of care.

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Home Health

1. Member must be CMC or Medi-Cal/HK assigned to:
    a. Independent Physician's
    b. Palo Alto Medical Foundation- Medi-Cal only
    c. All networks Out of Area and Non Contracted Provider - must be reviewed by nurse to determine emergent/ urgent necessity
    d. Any other network (VHP, Kaiser, PMG, Premier Care) redirect to delegated network for authorization.

2. Covered benefit for all LOB's when medically indicated. Must include:
    a. Plan of care
    b. MD order
    c. Documentation must include that "plan of care and MD order received"

3. Approve initial request ordered by contracted hospital or physician up to total of 11 visits (Combination of services: PT, OT, ST, Nurse, SW, HHA)

4. Initial request exceeding 11 visits must be forwarded to nurse for review.

5. All continued ongoing Home Health Services must be sent to nurse for review.
    a. Treatment plan and most recent progress notes required

Hospice Room and Board for Non-Contracted Providers

1. Member must be Medi-Cal with Medicare primary (Medicare does not cover room and board) assigned to:
    a. Independent Physician's
    b. Palo Alto Medical Foundation
    c. Any other network (VHP, Kaiser, PMG, Premier Care) redirect to delegated network for authorization if within the month of and the month after admission date.

2. Covered benefit for all LOB's when medically indicated. Must include:
    a. Hospice admission notification

3. This applies to non-contracted Hospice Providers. (Contracted hospice providers does not require authorization and can bill directly through claims)

4. Room and board authorization must be requested by Hospice agency and not by SNF.

5. Care coordinator may approve up to 90 days.

6. Additional days beyond 90 days must come with new hospice certification order, then can be approved by care coordinator.

7. Authorizations are reimbursed with Medi-Cal rates. No Letter of agreement (LOA) will be processed.

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Hearing Aid

1. Member must be **CMC** or Medi-Cal/HK assigned to:
    a. Medicare Primary
    b. Independent Physician's
    c. Palo Alto Medical Foundation- MC only
    d. Any other network redirect to group

2. Covered benefit for all LOB's when medically indicated

3. Current Audiology exam done by an Audiologist

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Hearing Aid – Repair

1. Member must be **CMC** or Medi-Cal/HK assigned to:
   a. Medicare Primary
   b. Independent Physician's
   c. Palo Alto Medical Foundation- MC only
   d. Any other network redirect to group

2. Covered benefit for all LOB's when medically indicated

3. Need information of current hearing aids and reason for repair
   a. Purchase date
   b. Serial number

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Non-Emergency Transportation

1. Member can be assigned to any/all networks all Lines of Business except Medi-Cal dual with Medicare part B primary
   *Medicare part B covers ambulance transportation for Facility to Facility.
2. Provider must sent authorization request for and PCS form including start and end date of NEMT/gurney ambulance services.
3. Non emergency ground transportation-Approve x 1.
4. Non emergency ground transportation for Dialysis-Approve up to 1 year for initial and reauthorization.
5. Non emergency Air transportation-Forward to nurse for review.
6. Non Medical Transportation (wheelchair van, litter van, cab, etc.) are processed within Customer Service.

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Behavioral Health Treatment (BHT) Guidelines

1. Member must be Medi-Cal or Healthy Kids and assigned to:
    a. Independent Providers
    b. Palo Alto Medical Foundation (PAMF)
    c. Physician's Medical Group (PMG)
    d. Premier Care (Conifer)
    e. Valley Health Plan (VHP) and Kaiser are delegated for BHT
2. A Prior Authorization Request (PAR) must be received by SCFHP from either a licensed physician or licensed psychologist. The appropriate ICD 10 code, typically, (F 84.0) must be identified on the PAR
3. Comprehensive Diagnostic Evaluations (CDEs) which are authorized by a licensed physician or psychologist are also accepted with a diagnosis of Autism or any other approved diagnosis per APL 15-025.
4. The Coordinator will enter an authorization approving up to 10 hours for up to two months for a BHT assessment.
5. If there is not a specified provider identified initially, the authorization will be approved to an unspecified provider and then changed when a provider is identified.
6. Authorizations will be initiated according to UM guidelines:
    a. 72 hours for Urgent Requests
    b. 5 Business Days for Routine
    c. 30 Days for Retroactive
7. The Health Plan has 15 business days to identify a provider to complete the initial assessment.
8. Following the initial assessment where goals and treatment plans are identified, the plan will be approved for 180 days per APL 15-025.
9. Any request which is greater than 25 hours per week for Direct Services will be reviewed by the Behavioral Health Director and may require a case conference with the provider.

Santa Clara
Family Health Plan
The Spirit of Care

Utilization Management Committee (UMC)

January 2018

UMC Goals and Objectives

- Compare SCFHP utilization levels against relevant industry benchmarks and monitor utilization trends among SCFHP membership over time
- Analyze key drivers and potential barriers, prioritize opportunities for improvement, and develop interventions that promote high-quality and cost-effective use of medical services

Inpatient Utilization: Medi-Cal – Non-SPD
7/1/2016 – 6/30/2017

Source: Medi-Cal Enrollment & Xpress Claims/Encounter Data

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2016 Q3	2,524	3.75	10,229	4.05
2016 Q2	2,305	3.38	10,063	4.37
2017 Q1	2,568	3.83	10,861	4.23
2017 Q2	2,467	3.72	9,357	3.79
Total	9,864	3.67	40,510	4.11

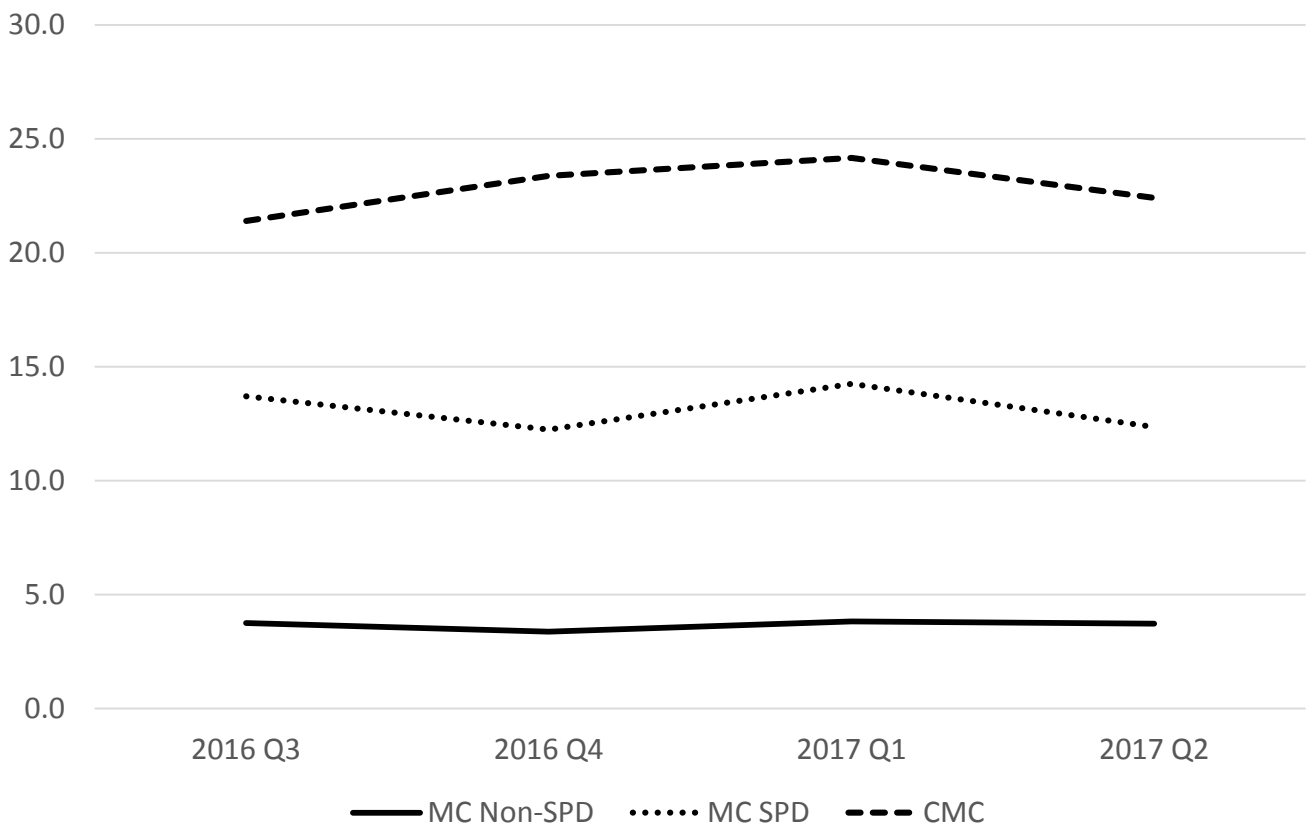
Inpatient Utilization: Medi-Cal – SPD
7/1/2016 – 6/30/2017
Source: Medi-Cal Enrollment & Xpress Claims/Encounter Data

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2016 Q3	847	13.71	4,288	5.06
2016 Q4	777	12.24	4,839	6.23
2017 Q1	914	14.25	4,573	5.00
2017 Q2	796	12.36	4,013	5.04
Total	3,334	13.13	17,713	5.31

Inpatient Utilization: Cal MediConnect (CMC)
7/1/2016 – 6/30/2017
Source: CMC Enrollment & QNXT Claims Data

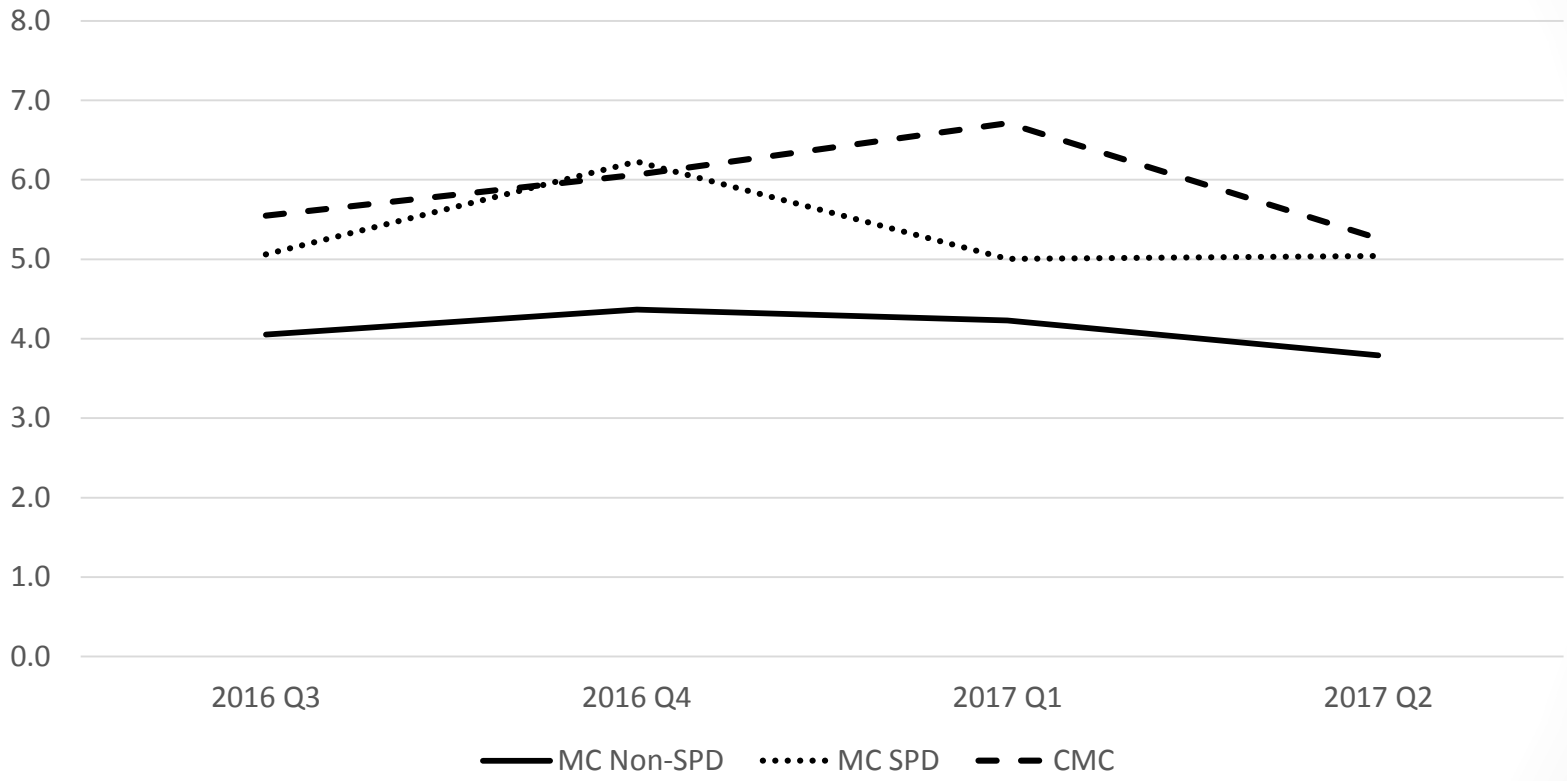
Quarter	Discharges	Discharges / 1,000 Members per Year	Days	Average Length of Stay
2016 Q3	491	256.8	2,724	5.55
2016 Q4	512	280.4	3,104	6.06
2017 Q1	532	289.9	3,571	6.71
2017 Q2	489	268.8	2,573	5.26
Total	2,024	273.8	11,972	5.92

SCFHP Medi-Cal & Cal MediConnect
Acute Inpatient Discharges per 1,000 Member Months (MM)
7/1/2016 – 6/30/2017



Statewide inpatient admissions per 1,000 MM as of March 2016:
SPD – 34
Dual – 31
ACA – 8
OLTIC – 2
Other – 4

SCFHP Medi-Cal & Cal MediConnect
Acute Inpatient Average Length of Stay (ALOS)
7/1/2016 – 6/30/2017



Santa Clara Family Health Plan
The Spirit of Care

1/9/2018

Medi-Cal Inpatient Utilization
NCQA Medicaid Benchmark Comparisons
7/1/2016 – 6/30/2017

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	3.67	13.13	4.49
NCQA Medicaid Percentile Rank[1]	<10th	>75th	<10th
ALOS	4.11	5.31	4.41
NCQA Medicaid Percentile Rank[2]	>50th	>90th	>50th

[1] NCQA Medicaid 50th percentile = 6.82
[2] NCQA Medicaid 50th percentile = 4.10

Santa Clara Family Health Plan
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Medi-Cal SPD & CMC Inpatient Utilization
MCG & NCQA Medicare Benchmark Comparisons
7/1/2016 – 6/30/2017

	Discharges / 1,000 Members per Year	Days / 1,000 Members per Year	ALOS
SCFHP Population			
Medi-Cal SPD	157.6	837.4	5.31
CMC	273.8	1,619.5[1]	5.92
MCG Medicare Plans			
Loosely Managed	258.7	1,406.9	5.44
Moderately Managed	214.8	1,078.7	5.02
Well Managed	171.0	750.6	4.39
NCQA Medicare Mean	218.7	1,213.1	5.29

[1] CMC inpatient days / 1,000 = 1,289.1 for 6 CCI counties through 9/30/16; in comparison, a 5% sample of 2015 Medicare FFS data for the same counties showed inpatient days / 1,000 = 2,502.6

Inpatient Readmissions: Medi-Cal – Non-SPD

Source: All Cause Readmissions (ACR) data for 7/1/2016 – 6/30/2017 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2016 Q3	1,190	190	15.97%
2016 Q4	1,090	159	14.59%
2017 Q1	1,280	216	16.88%
2017 Q2	919	159	17.30%
Total	4,479	724	16.16%

[1] A lower rate indicates better performance.

[2] The 30-day readmission rate for the ACR measure is Medi-Cal specific and only includes non-dual members ages 21 years and older.

Inpatient Readmissions: Medi-Cal – SPD

Source: All Cause Readmissions (ACR) data for 7/1/2016 – 6/30/2017 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1]
2016 Q3	587	146	24.87%
2016 Q4	508	116	22.83%
2017 Q1	648	166	25.62%
2017 Q2	444	109	24.55%
Total	2,187	537	24.55%

[1] A lower rate indicates better performance.

[2] The 30-day readmission rate for the ACR measure is Medi-Cal specific and only includes non-dual members ages 21 years and older.

Inpatient Readmissions: Cal MediConnect (CMC)

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 7/1/2016 – 6/30/2017 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2016 Q3	324	44	13.58%
2016 Q4	364	44	12.09%
2017 Q1	378	54	14.29%
2017 Q2	245	35	14.29%
Total	1,307	177	13.54%

[1] A lower rate indicates better performance.

[2] The PCR rate applies only to SCFHP's CMC line of business and includes members 18 years of age and older.

Cal MediConnect (CMC) Readmission Rates Compared to NCQA Medicare Benchmarks

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 4/1/2016 – 3/31/2017 measurement period

Rate Description	Ages 18 – 64 (PCR-A)	Ages 65+ (PCR-B)
Count of Index Hospital Stays	301	1,006
Count of 30-Day Readmissions	33	144
Actual Readmission Rate	10.96%	14.31%
NCQA Medicare 50th Percentile	16.78%	13.07%
SCFHP Percentile Ranking	>75th	>25th

[1] A lower rate indicates better performance.

[2] The PCR rate applies only to SCFHP's CMC line of business and includes members 18 years of age and older.

Frequency of Selected Procedures: Medi-Cal

Source: HEDIS data for 7/1/2016 – 6/30/2017 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Tonsillectomy				
Male & Female, Age 0-9	208	0.30	0.62	↓
Male & Female, Age 10-19	75	0.11	0.27	↓
Hysterectomy, abdominal				
Female, Age 15-44	15	0.02	0.13	↓
Female, Age 45-64	31	0.10	0.27	↓
Hysterectomy, vaginal				
Female, Age 15-44	12	0.02	0.12	↓
Female, Age 45-64	21	0.07	0.19	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 7/1/2016 – 6/30/2017 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Cholecystectomy, open				
Male, Age 30-64	1	0.00	0.02	↓
Female, Age 15-44	5	0.01	0.01	↔
Female, Age 45-64	0	0.00	0.03	↓
Cholecystectomy, closed (laparoscopic)				
Male, Age 30-64	55	0.12	0.27	↓
Female, Age 15-44	177	0.28	0.63	↓
Female, Age 45-64	81	0.26	0.62	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 7/1/2016 – 6/30/2017 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Back Surgery				
Male, Age 20-44	8	0.02	0.24	↓
Female, Age 20-44	18	0.04	0.16	↓
Male, Age 45-64	35	0.13	0.56	↓
Female, Age 45-64	27	0.09	0.49	↓
Mastectomy				
Female, Age 15-44	17	0.03	0.02	↑
Female, Age 45-64	24	0.08	0.14	↓
Lumpectomy				
Female, Age 15-44	40	0.06	0.12	↓
Female, Age 45-64	72	0.23	0.37	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 7/1/2016 – 6/30/2017 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Bariatric Weight Loss Surgery				
Male, Age 0-19	0	0.00	0.00	↔
Female, Age 0-19	0	0.00	0.00	↔
Male, Age 20-44	2	0.01	0.01	↔
Female, Age 20-44	32	0.07	0.05	↑
Male, Age 45-64	3	0.01	0.01	↔
Female, Age 45-64	16	0.05	0.05	↔

Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 7/1/2016 – 6/30/2017 measurement period

Measure	Rate	NCQA Medicaid 50th Percentile	SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	32.34%	42.19%	<25th
Continuation & Maintenance Phase	27.87%	52.47%	<10th
Antidepressant Medication Management			
Acute Phase Treatment	60.79%	53.40%	>75th
Continuation Phase Treatment	41.82%	38.06%	>50th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	100.00%	80.00%	>90th

Santa Clara
Family Health Plan
The Spirit of Care

Questions?

Bariatric Surgeries by Procedure Code
7/1/2016 to 6/30/2017, LOB Medi-Cal

Code	Description	# of Procedures	Percentage
43644	LAP GASTRIC BYPASS/ROUX-EN-Y	44	69.8%
43645	LAP GASTRIC BYPASS INC SMLL I	16	25.4%
43772	LAP REMOVE GASTRIC ADJ DEVICE	2	3.2%
43774	LAP REMOVE GASTRIC ADJ ALL PARTS	1	1.6%
Grand Total		63	100.0%

Santa Clara
Family Health Plan

InterRater Reliability Summary
2017

1. In accordance with Policy HS.09, the 2nd bi-annual Calendar Year 2017, Santa Clara Family Health Plan (SCFHP) scheduled IRR testing is complete. This is required twice a year. IRR testing is scheduled for SCFHP 1st and 2nd half of the calendar year. In accordance with NCQA/DHCS, DMHC guidelines, and SCFHP policy, 10 random BH authorizations are selected to test BH staff with the authority to Authorize services. Our BH staff consists of non-licensed Personal Care Coordinators (PCC) & our Director of Behavioral Health (LCSW).
2. In the calendar year 2017, SCFHP updated the policy from individual testing to group testing to provide support to our staff.
3. It is the policy of SCFHP to monitor the consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians - who are responsible for conducting Behavioral Health service reviews and to act on improvement opportunities identified through this monitoring.
4. The Chief Medical Officer or Director of Behavioral Health will review and approve the assessment report of decision making performance of staff responsible for conducting Behavioral Health approval reviews for BH staff. The report results and recommendations for improvement will be presented annually to the Utilization Management Committee.
5. The Plan classifies reviews into one of two performance categories: Proficient (80% - 100% of the records are in compliance with the criteria); Not proficient (below 80% in compliance) Scores below 80% require increased focus by Supervisors/Managers with actions described in Policy/Procedure HS.09/HS.09.01 or an individual corrective action plan.

The following are the findings for all UM staff tested on December 8th, 2017:

Reviewer	Percent Score	UM Staff Position	Pass/Failed
1	95	Director of Behavioral Health	Pass
2	100	Behavioral Health PCC	Pass
3	87	Behavioral Health PCC	Pass

In the first testing, we found that 100% or 3/3 of our staff are proficient during this review. 100 percent of BH staff who complete authorizations completed the IRR testing.

Our common finding after the testing process was:

1. Staff who are authorized to review/approve BH services through SCFHP express comfort in knowing the process/where to go to for clarification.

The corrective action's plan after identifying the common findings would be:

1. Mandatory remedial training with post testing for all non-proficient staff (should this be required – not needed at this time).
2. Mandatory bi-annual review of guidelines and criteria, as well as biannual testing, will continue to be scheduled.

January 4, 2018

Referral Tracking Annual Report 2017

In accordance with the SCFHP Referral Tracking Procedure HS. 01.02, SCFHP tracks all authorizations, for completion of the "authorization to claims paid" cycle, to identify opportunities for improvement. By definition all authorizations are defined as: 1. both contracted and non-contracted prior authorizations and 2. behavioral health and non-behavioral health authorizations are tracked to completion. SCFHP (The Plan) has a referral tracking system which tracks approved, modified, deferred medical and behavioral health prior authorizations to completion on an ongoing basis.

DATA

The first report was completed for the rolling 12 month look back of:

- December 2016 to November 2017

There were 14,447 unique authorizations (auths) for all lines of business (roughly 1200 auths / month). A big surprise was that 9197 auths had no claims match, which was 64% -- see table 1 below. However, we did identify administrative barriers, i.e. claim lag time. There are 2200 (24%) auths with September, October, and November dates which likely will not have a claim because of the claim submission lag.

See table 1 below

Count of Authorization Number. Table 1	
Row Labels	**Grand Total NO CLAIM MATCH**
2016-12	773
2017-01	863
2017-02	852
2017-03	1084
2017-04	766
2017-05	783
2017-06	662
2017-07	468
2017-08	696
2017-09	671
2017-10	708
2017-11	871
Grand Total	**9197**

Additionally the table was sorted to show the highest count of unmatched claims to auth by category of service.
The top 5 categories of service accounted for 90% of the non-matched claims to auths. These are highlighted by month in Table 2.

Count of Authorization Number. Table 2	Column Labels				
Row Labels	**OPHospital**	**MEDICAL**	**DME**	**OPHospitalGr**	**HomeHealth**
2016-12	496	99	7		19
2017-01	537	109	10		20
2017-02	568	121	10		11
2017-03	698	178	20		32
2017-04	678	31	16		17
2017-05	701	30	18		12
2017-06	528	60	32	3	20
2017-07	363	22	37	2	20
2017-08	494	78	52	5	33
2017-09	529	2	67	18	31
2017-10	445		80	113	47
2017-11	424	1	70	224	67
Grand Total	**6461**	**731**	**419**	**365**	**329**

We also specifically looked at the BH claim to auth mismatch and found the following (Table 3):

1. The total numbers were very small. 152 total auths without claims (1.6%)
2. The October and November higher numbers are likely related to billing not yet submitted.

BH Count of Authorization Number. Table 3				
Row Labels	**OP-Behavorial**	**OP-BehavioralGr**	**Behavioral Health Outpatient**	**ABA**
2016-12	2		1	2
2017-01	4			1
2017-02	8	1	3	1
2017-03	3		3	
2017-04	6	1	2	3
2017-05	4		2	4
2017-06	3	6		
2017-07	9	4		
2017-08	6	9		
2017-09	8	13		
2017-10	4	12		
2017-11	11	16		
Grand Total	**68**	**62**	**11**	**11**

January 4, 2018

Referral Tracking Annual Report 2017

ANALYSIS:

Given the large variance in the claim to auth match from the previous year, the UM management team did a strategic focused calling campaign. Instead of the 50 calls required by the policy, a total of 175 random outbound calls were made to members.

Based on the call information and procedure type was collected, the top Procedures without a match were:

Count of Authorization Number Procedure	Grand Total
ALL MRI ++	38
Hearing AID	21
Physical Therapy	20
MRI Spinal (++included above)	12
EEG	9
MRI Brain (++included above)	8
Podiatry	6
Transportation	6
psych and therapy	5

Based on our outbound call campaign, the major reasons for auths not completed were:

Reason							
Closed	Auth Denied	Done Per Pt	Per Pt. Missed Appt	Per Pt. Not Done	Member Term	UTR	Grand Total
2	22	15	1	3	52	80	175

UTR = Unable to Reach member by phone call

Additionally: based on the Procedure HS 01.02 Referral tracking requires the UM department to analyze the following information:

i. Types of auths by LOB not completed
   I. There were 10024 Medi-Cal authorizations. 7192 did not have a matching claim (72%)
   II. There were 4373 CMC authorizations, 2005 did not have a matching claim (46%)
   III. There were 36 Healthy Kids authorizations, 27 without claims (75%)
   IV. There were 14 Agnews authorizations, 11 had no matching claims and all were for a dental surgery center.

ii. Types of auths completed with the timeliness of the service delivery as noted by the claim date of service.
   I. This item was collected for the rolling 12 months, however, as the CAP (corrective action plan) to DHCS was not finalized until 12/5/2017, this item was not fully QA'd. the IT and UM department is assisting with finalizing this data and it will be presented in second quarter 2018.

iii. Services not completed by LOB; please see table 2 above. The service categories for all auths were completed. The breakdown by LOB is pending (CAP was finalized with DHCS 12/5/2017)

iv. Timeliness of authorization completion by level of urgency by LOB iv. Provider type / provider profile of the authorizations not completed by LOB

v. The plan will track all authorization types for the purpose of ensuring authorizations are completed *timely*. Approved authorizations will be tracked to completion of the service by reviewing the date of the service on the submitted claim. The difference between the auth issue date and claim service date will be acquired. This is to assess the completion of the authorized services will be and then reviewed, analyzed. And the findings will be reported to UMC (for possible suggested actions).
   I. Data not completely QA'd and will be available second quarter 2018.

January 4, 2018

Referral Tracking Annual Report 2017

FINDINGS:

1. Auths moved to QNXT for Medi-Cal in June 2017. Claims started to pay in QNXT for all lines of business in July 2017.
2. The hypothesis was perhaps that the auth payments from Xpress were not captured.
    a. However, UM confirmed with IT that despite the conversion of systems to QNXT and the sunset of Xpress, that the claim payment information was obtained from both systems. IT did confirm that all claims payment from both systems were included.
3. Additionally UM checked with claims on any backlog of claim payment and it was confirmed that there was no current claims backlog.
4. UM undertook a calling campaign to the patient population which was larger than that required by HS.01.02 procedure (referral tracking). Random calls were made to 175 patients.
    a. UM calls identified several issues with the data, which were not realized.
        i. Denied / cancelled claims were included
        ii. Members who termed were included
5. Based on call campaign, and excluding denied and termed patients the total auth volume was recalculate at 101.
        i. Additionally, 80/101 (79%) members were not reached (however, because of time issues only one call was made)
        ii. 19/101 patients (19%) either had the procedure or selected not to do it / missed their appointment
6. Based on calls, MRI, Hearing Aids, and physical therapy were the highest unpaid procedures.

NEXT STEPS and FOLLOW UP:

1. The UM management team worked diligently with DHCS on the CAP for the referral tracking processes. However, because of timing reasons (CAP finally approved 12/5/2017) and data run cycle, there were data quality issues discovered after telephone calling occurred. These are being actively pursued.

2. The number of authorizations without claims is higher than anticipated. Additionally it is higher than the previous study of December 13, 2016.

    a. SCFHP UM management believes that this is multifactorial and includes:
        i. Issues with the data , The data run for January 2017 – December 2017 will:
            1. The data included all lines of business
            2. The data included termed patients (lost their eligibility)
            3. The data included denied / closed auths

4. The data included the months of October, and November. Therefore there were administrative issues including claim lag time. Because of the change in the procedure Referral Tracking HS 01.02, there are 2200 (24%) auths with September, October, and November dates. These are unlikely to match to a claim because of the claim lag.

The UM Department refers members to Case Management when member barriers are identified.

As the calling campaign indicated there were 38 unique patients with approved MRI's that did not receive the service. These members were further studied. We found the following:

i. 13 patients lost eligibility
ii. 17 were unable to be reached
iii. 3 were denied
iv. 2 patients stated they completed the study
v. 2 patients did not go to complete study
vi. 1 auth was closed
    - Therefore the 17 patients that were unable to be reached were sent to CM for assistance

Santa Clara Family Health Plan is committed to working on improving the service delivery systems to our members. As such, the UM team will continue it's monthly monitoring and quarterly reporting to UMC. The changes required above are being actively pursued and report of our progress will be submitted quarterly to UMC.

Santa Clara
Family Health Plan

I. Purpose of the Quality Assurance (QA)

In order to present the results to Utilization Management Committee (UMC), Santa Clara Family Health Plan (SCFHP) completed the 4th quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations.

II. Procedure

Santa Clara Family Health Plan reviewed in accordance to this procedure, 30 authorizations for the 4th quarter 2017 in order to assess for the following elements.

A. Quality Monitoring

1. The UM Manager is responsible for facilitating a random review of denial letters to assess the integrity of member and provider notification.
    a. At least 30 denial letters per quarter
    b. Is overseen by the Utilization Management Committee on a quarterly basis
    c. Assessment of denial notices includes the following:
        1. Turn-around time for decision making
        2. Turn-around time for member notification
        3. Turn-around time for provider notification
        4. Assessment of the reason for the denial, in clear and concise language
        5. Includes criteria or Evidence of Benefit (EOB) applied to make the denial decision and instructions on how to request a copy of this from UM department.
        6. Type of denial: medical or administrative
        7. Addresses the clinical reasons for the denial
        8. Specific to the Cal Mediconnect membership, the denial notification includes what conditions would need to exist to have the request be approved.
        9. Appeal and Grievance rights
        10. Member's letter is written in member's preferred language within plan's language threshold.
        11. Member's letter includes Independent Medical Review (IMR) information or state fair hearing rights
        12. Member's letter includes interpretation services availability
        13. Member's letter includes nondiscriminatory notice.
        14. Provider notification includes the name and direct phone number of the appropriately licensed professional making the denial decision

Quarterly Quality Report in Accordance with Procedure HS.04.01
For 4th Quarter 2017

III. Findings

For the 4th quarter review of 2017, the findings are as follows:

A. For the dates of services and denials for October, November and December of CY 2017 were pulled in the 4th quarter sampling year.
    a. 30 unique authorizations were pulled with a random sampling.
        i. 93% or 28/30 Medi-Cal LOB and 7% or 2/30 CMC LOB
        ii. Of the sample 100% or 30/30 were denials
        iii. Of the sample 37% or 11/30 were expedited request; 63% or 19/30 were standard request
            1. 100% or 11/11 of the expedited authorizations were processed within 72 calendar hours
            2. 100% or 19/19 of the standard authorizations met regulatory turnaround time
        iv. 20% or 6/30 are medical denials, 80% or 24/30 are administrative denials
        v. 100% or 30/30 of cases were denied by MD or pharmacist.
        vi. 100% were provided member and provider notification.
        vii. 6% or 2/30 have poor letter quality, 94% or 28/30 have good letter quality.
        viii. 53% or 16/30 included criteria or EOB in the letter, 47% or 14/30 did not include criteria or EOB language for administrative denials.
        ix. 100% of the letters included IMR information, interpreter rights and instructions on how to contact CMO or Medical Director.
        x. 100% of the member letters are of member's preferred language.

IV. Follow-Up

The Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from that finding presented to UMC are as follows:

1. Include EOB language for admin denials.
2. Provide staff education to re-read denial letters for letter quality.
3. Continue QA report monitoring process.

Peer to Peer Annual Review Calendar Year (Year to Date) 2017

In accordance with Procedure HS.02.02, the provider dispute process also includes a Peer to Peer (P2P) review with the SCFHP physician who makes the determination (in cases of denials of service). It is the goal of SCFHP medical director team to ensure quality of service and return of calls when there is a requested P2P. The telephone number to schedule those calls is sent out with each of the denied cases.

For YTD 2017, there were 22 total requests for Peer to Peer Reviews.

SCFHP selected 10 random samples. This was to ensure that the Peer to Peer process is working and that community physician requests for call back are completed and do in fact occur.

The selection included 5 for each of the two physicians at SCFHP.

The findings are as follows:

1. 90% or 9/10 calls were completed with the SCFHP physician and the requesting physician.
2. 90% had documentation of the call, however not in our claims payment system. Most documentation was via an email to the team and the admin assistant.
3. 40% of decisions had documentation in the QNXT or Xpress systems.
4. 33% of decisions were upheld. And the rest were overturned.

SCFHP recommendation to UMC:

1. Corrective Action:
    a. Since 6/2017, QNXT is the one system that now holds authorizations for all Lines of Business (Medi-Cal , Cal MediConnect, and Healthy Kids). As such both physician know the system and have agreed to enter their call documentation into QNXT.
    b. The Procedure HS 02.02 was also updated to include the annual review of the P2P process and presented to the Chief Medical Officer for approval.

c. The Annual Review of the Peer to Peer Process was added to the Yearly UM Committee review items and will be conducted yearly.

Request Date	Outcome	Reviewer	Called y or n, if no why	Documentation of call by HP MD in xpress or qnxt	Comments
2/6/17	Forwarded to G&A, upheld	Lily Boris	yes	no	
4/6/17	overturn	Lily Boris	yes	no	Qnxt no info , xpress min info
5/31/17	Denial upheld; sent to G&A,	Lily Boris	yes	yes	
8/29/17	Overturned	Lily Boris	yes	no	
10/23/17	Overturned	Lily Boris	yes	no	
1/18/17	Overturned	Jeff Robertson	yes	yes	
5/3/17	Overturned	Jeff Robertson	yes	yes	
10/24/17	Overturned	Jeff Robertson	yes	no	
3/24/17	Forwarded to G&A	Jeff Robertson	Scheduled but no call	no	
11/29/17	To be submitted as a new request with	Jeff Robertson	yes	yes	

	documentation				