Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, January 16, 2019, 6:30-8:00 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave., San Jose, CA 95119

AGENDA

1.	**Introduction**	Dr. Boris	6:30	5 min.
2.	**Meeting Minutes** Review minutes of the October 17, 2018 Utilization Management Committee meeting. Possible Action: Approve 10/17/18 minutes	Dr. Boris	6:35	5 min.
3.	**Public Comment** 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 to 30 minutes.	Dr. Boris	6:40	5 min.
4.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	6:45	10 min.
5.	**CMO Update** NCQA (Survey submitted 12/11/2018, Onsite Feb 4-5 2019) DHCS/DMHC (Onsite is March 18-22, 2019) CMS Independent Validation Audit (Possibly May – July 2019) VHP DOFR Changes	Dr. Robertson	6:55	5 min.
6.	**Old Business/Follow up items** a. Presenting the MCG Criteria as requested by the committee for Colonoscopy, EGD, and UptoDate criteria for Frenulectomy b. Update on SNF to LTC conversions for the last 6 months	Ms. Castillo	7:00	10 min.
7.	**Action Items** a. UM Program Description 2019 **Possible Action:** Approve UM Program Description b. Annual Review of UM Policies i. HS.01 Prior Authorization ii. HS.02 Medical Necessity Criteria	Ms. Castillo	7:10	10 min.

iii. HS.03 Appropriate Use of 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
xiii. HS.13 Nurse Advice Line
xiv. HS.14 Transportation Services
xv. HS.15 Long Term Care Utilization Review

Possible Action: Approve UM Policies as presented.

8. **Reports (MediCal/SPD, Healthy Kids)**

a. Membership	Dr. Robertson	7:20	5 min.
b. UM Reports 2018	Ms. Castillo	7:25	5 min.
i. Dashboard Metrics: Turn Around Time (Cal MediConnect/ Medi-Cal)			
ii. Standard Utilization: Metrics Powerpoint			
c. MLTSS Dashboard	Dr. Boris	7:30	5 min.
d. HS.04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q4 18)	Ms. Castillo	7:35	5 min.
e. Referral Tracking Annual Report	Ms. Castillo	7:40	5 min.
f. Nurse Advice Line Stats	Ms. Carlson	7:45	5 min.
g. Annual report on physician peer to peer process	Dr. Boris	7:50	5 min.
h. Conflict of Interest Forms	Dr. Boris	7:55	1 min.

9. **Behavioral Health UM Reports** — Ms. McKelvey 7:56 4 min.
   i. Turn Around Time/Dashboard Metrics
   ii. Technical Assistance Guide (TAG) update for Behavioral Health
   iii. DMHC findings update and recommendations
   iv. ASD evaluation of timely screening and diagnosis for CY 2018

10. **Adjournment** — Dr. Boris 8:00

Next meeting: Wednesday, April 17, 2019 6:30 p.m.

Notice to the Public—Meeting Procedures

- Persons wishing to address the 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 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 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
October 17, 2018

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	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

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

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:05 PM. There was a motion to approve the July 18, 2018 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	

ITEM	DISCUSSION	ACTION REQUIRED
IV. CEO Update	Dr. Robertson presented the CEO update. The health plan moved to new location on July 30th. Participated in CMS audit, now working on corrective actions. New Chief Medical Officer Laurie Nakahira starts on October 31st.	
V. Old Business/Follow up items	Ms. Castillo presented some follow up items from the July 18th UM committee meeting. Presented authorization data for gastric bypass as well as criteria for gastric bypass. Six authorizations were pulled for date range of June 1st to August 31st of 2018. Age range of members ranged from 26 to 59 years of age, BMI ranged from 39 to 63. Reviewed guidelines for Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy as well as with Gastric Bypass.	No action required.
VI. Action Items	a. Prior Authorization Grid approval Ms. Castillo presented the 2019 Prior Authorization Grid. New grid combines all lines of business. Created a separate grid for medications (2019 Medical Benefit Drug Prior Authorization Grid). b. UM Program Evaluation 2017 Cal MediConnect Ms. Castillo presented the 2017 UM Program Evaluation for Cal MediConnect. Santa Clara Family Health Plan evaluates its Utilization Management (UM) Program annually to determine their overall effectiveness, identify needed improvements, and assess progress toward improvement of annual goals. The annual evaluation is also used to identify goals, trends, work plan activities, and opportunities for improvement in the coming year. SCFHP has a UM Program that objectively monitors and evaluates appropriate UM services delivered to members which operates with the principles outlined in the program. 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.	Approved as presented. Approved as presented.

ITEM	DISCUSSION	ACTION REQUIRED
VII. Reports	The 2017 UM program evaluation resulted in program changes. The UM program and UM policies were described to have it available for members and providers, the UM staff description was updated as staffing changes and expansion were implemented in mid-2017, Practitioner and member satisfaction monitoring were included, and Behavioral Health staff involvement was defined. These changes are outlined in the 2018 Program description. They are made to meet regulatory requirement and to ensure effectiveness of the program structure. UM continues to strive to meet regulatory requirements that are written in the 2018 UM Program description and to meet goals described in the 2018 UM work plan a. Membership Dr. Robertson presented the update on membership. As of October, membership is at 255,311. Membership remains flat. b. UM Reports 2018 i. Dashboard Metrics Dr. Boris presented the Dashboard Metrics report. Monitoring compliance based on turnaround time. Divided by lines of business. For CMC line of business, at 99.5% of compliance for routine requests, 98.7% compliant for expedited/urgent requests, 96.8% compliant for retro requests. For Medi-Cal line of business, 98.7% compliant for routine, urgent 99.4 %, retro 99.3%. Have implemented outbound calls to members and providers. Call member and inform them authorization is approved, fax provider immediately with letter and follow up with a call. ii. Standard Utilization Metrics Data is for July 1, 2017 to June 30, 2018. For MediCal/non SPD, discharges per thousand is at 3.68, with average length of stay 3.55. For Medi-Cal SPD discharges per thousand are at 11.82. Average length of stay 4.83. For CMC population 6.11 days average length of stay. Discharges per thousand 267.7. For NCQA Medicaid Benchmark Comparisons, Non SPD fall at less than 10%, SPD falls at greater than 90%. Combined total is less than 50% percentile ranking for average length of stay. Medi-Cal SPD's 141.9 discharges per thousand, CMC is at 262.7 per thousand. Average length of stay is 4.83 for Medi-Cal SPD and 6.11 for CMC. Inpatient Readmissions Medi-Cal Non SPD is at 15.57%. SPD Inpatient Readmissions for Medi-Cal overall average of 21.71%. Readmissions on CMC at 16.5%. NCQA Benchmark comparison for CMC Readmissions: Ages 18 to 64 readmission rate of 24.01%; Ages 65+	

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	readmission rate of 13.52%. For age 18 to 64, greater than 90th percentile ranking, age 65+, greater than 50th percentile ranking. (Lower rate indicates better performance). Frequency of selected procedures have ranged where they have been. c. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q3 18) Ms. Castillo presented the Q3 2018 Quality Monitoring Report. Santa Clara Family Health Plan (SCFHP) completed the 3nd quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 3nd Quarter review of 2018, the findings are as follows: A. For the dates of services and denials for July, August and September of CY 2018 were pulled in the 3rd quarter sampling year. a. 30 unique authorizations were pulled with a random sampling. i. 57% or 17/30 Medi-Cal LOB and 43% or 13/30 CMC LOB ii. Of the sample 100% or 30/30 were denials iii. Of the sample 40% or 12/30 were expedited request; 60% or 18/30 were standard request. 1. 100% or 12/12 of the expedited authorizations met regulatory turnaround time of 72 calendar hours 2. 89% or 16/18 of the standard authorizations met regulatory turnaround time, 11% or 2/18 are non-compliant with regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB) iv. 67% or 20/30 are medical denials, 33% or 10/30 are administrative denials v. 93% or 28/30 of cases were denied by MD, 7% or 2/30 cases were denied by a pharmacist vi. 100% or 30/30 were provided member and provider notification. vii. 58% or 7/12 expedited authorizations were provided oral notifications to member. viii. 83% or 25/30 of the member letters are of member's preferred language. ix. 100% or 30/30 of the letters were readable and rationale for denial was provided. x. 97% or 29/30 of the letters included the criteria or EOC that the decision was based upon.	

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	xi. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact CMO or Medical Director 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: • Provide staff training regarding oral notification to member following an expedited service authorization determination. • Provide staff training in managing regulatory turnaround time based on LOB. • Monitor other causes of untimeliness such as FDRs and escalate it to compliance. • Provide staff training in checking member's preferred language when sending member's UM letters. • Continue QA monitoring and reporting. d. Referral Tracking Ms. Castillo presented the Referral Tracking report for Q318. Not much claims authorization activity in August. Do a 3 month look back. 56.8% of authorizations have matched a claim for Cal Medi-Connect line of business. 55% of authorizations have matched a claim for Medi-Cal line of business. Do outbound calls to members to find out why the appointment was never attended or scheduled. Present to UM committee the findings. Dr. Tobaggi asked if there are members complaining they are not getting appointments and why we are doing these statistics. Dr. Boris explained DMHC requested data. e. Nurse Advice Line Stats Ms. Carlson presented the Nurse Advice Line Stats. Medi-Cal received 942 calls, Healthy Kids 15 calls, Cal MediConnect calls 45 during the third quarter of 2018 (September 2018 data not yet received). For Medi-Cal 31 triage dispositions rendered to call 911/EMS immediately. For Cal MediConnect, 4 triage dispositions were rendered to call 911/EMS immediately. For Health Kids, no triage dispositions rendered to call 911/EMS immediately. Highest volume for Triage Guidelines used for call types: Medi-Cal-CareNet Health Information only, Abdominal/Pelvic Pain, Abnormal vaginal bleeding, urinary symptoms (female), allergic reactions	

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	Healthy Kids-CareNet Health Information only, Bites, Stings, Rash/Hives, Nasal allergies, Eye pus or discharge Cal MediConnect- CareNet Health Information only, BP Control problems, Insect bites/stings f. Interrater Reliability (Medical & Behavioral Health Q3) Twice a year staff is tested. Results are presented to UM Committee. For UM staff only 3 of 21 staff did not pass with score of 80% or higher. Most common reason was improper identification of required turnaround time for specific lines of business. Also lack of understanding for specific Care Coordinator guidelines and improper selection and application of clinical guidelines for medical review. The corrective action's plan after identifying the common findings are: • Mandatory remedial training and with retest for staff that were found non proficient within 1 month of the IRR test. Completed on 10/5/2018. • Continued training to all UM and MLTSS staff for all UM process and workflows to comply with regulatory standards. • UM management weekly monitoring as outlined in UM procedure and quarterly report to UM committee. Summary of the IRR remedial training: Attendees: All staff that were found non proficient in the IRR testing (1 coordinator and 2 licensed staff). Discussion topics: • Identification of lines of business • Regulatory turnaround time based on line of business • Care Coordinator Guidelines • UM Policy and procedure for Hierarchy of clinical criteria • Selection and application of clinical criteria, specifically MCG Retesting: 3 recreated hypothetical cases Scoring and passing score follows the same procedure as the IRR testing. All 3 staff that attended the remediation were re-tested and were found proficient. For behavioral health staff, 1 out of 3 staff did not pass with score of 80% or higher. Personal Care coordinator (PCC) was provided additional training on 9/27/18 and passed the re-test with a score of 90%. Retest was provided on 9/28/18. Findings were staff who are currently authorized to review/approve BH services through SCFHP express comfort in knowing the process/where to go for	

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	clarification. While ongoing support throughout the department is provided, additional training is required for new PCC to review process of authorizations. This training was provided on 9/27/2018 and retesting completed on 9/28/2018. The corrective action's plan after identifying the common findings are: • Mandatory remedial training with post testing for all non-proficient staff • Mandatory bi-annual review of guidelines and criteria, as well as biannual testing, will continue to be scheduled for all staff who complete Behavioral Health Authorizations.	
VIII. Behavioral Health UM Reports	Dr. Boris presented the Dashboard Metrics reports for Behavioral Health. Divided by lines of business. For CMC line of business, at 100% of compliance for routine requests, 100% compliant for expedited/urgent requests, 100% compliant for retro requests. For Medi-Cal line of business, 95.3% compliant for routine, urgent 85.7 %, retro 98.8%. Have implemented outbound calls to members and providers.	Pull 6 months of data for LTSS and present at next UM committee meeting

ITEM	DISCUSSION	ACTION REQUIRED
IX. Adjournment	Meeting adjourned at 7:30 PM	

ITEM	DISCUSSION	ACTION REQUIRED
NEXT MEETING	The next meeting is scheduled for Wednesday, January 16, 2019, 6:30 PM	

Prepared by:

_____ Date _____
Caroline Alexander
Administrative Assistant

Reviewed and approved by:

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

Colonoscopy

ACG: A-0129 (AC)
Link to Codes

MCG Health
Ambulatory Care
22nd Edition

Clinical Indications for Procedure

- Colonoscopy may be indicated for **1 or more** of the following:
  - Colon cancer screening, as indicated by **1 or more** of the following(3)(4)(5)(6)(7):N
    - Abnormal result of screening detected by **1 or more** of the following(6)(10)(11)(20):
      - Barium enema
      - CT colonography
      - Fecal DNA testing
      - Fecal immunochemical test
      - Fecal occult blood test
      - Sigmoidoscopy
    - Average-risk personal history,[A] as indicated by **ALL** of the following(3)(6)(14)(21):
      - Age 50 years or older, or African American age 45 years or older(8)
      - No colonoscopy in past 10 years(6)(10)
    - High-risk family history, as indicated by **1 or more** of the following(3):
      - Advanced adenoma (eg, high-grade dysplasia, diameter of 1 cm or greater, villous or tubulovillous histology) in first-degree relative[B] and **ALL** of the following:
        - Appropriate at-risk age, as indicated by **1 or more** of the following:
          - Age 50 years or older
          - Age is equal to age of onset of adenoma in first-degree relative.
        - No colonoscopy in past 5 years
      - Colorectal cancer diagnosed before age 50 years in one second-degree relative[C] and **ALL** of the following:
        - Age 50 years or older
        - No colonoscopy in past 5 years
      - Colorectal cancer diagnosed before age 60 years in one first-degree relative[B] and **ALL** of the following(10):
        - Appropriate at-risk age, as indicated by **1 or more** of the following:
          - Age 40 years or older
          - Age is 10 years younger than earliest age of diagnosis of colon cancer in first-degree relative.
        - No colonoscopy in past 5 years
      - Colorectal cancer diagnosed at age 60 years or older in one first-degree relative[B] and **ALL** of the following:
        - Age 50 years or older
        - No colonoscopy in past 5 years
      - Colorectal cancer diagnosed in 2 first-degree relatives[B] of any age and **ALL** of the following:
        - Appropriate at-risk age, as indicated by **1 or more** of the following:
          - Age 40 years or older
          - Age is 10 years younger than earliest age of diagnosis of colon cancer in first-degree relative.
        - No colonoscopy in past 5 years
      - Family member with familial adenomatous polyposis without identified mutation and **ALL** of the following(4)(23):
        - Adenoma previously detected by sigmoidoscopy
        - No colonoscopy in past year
    - High-risk personal history, as indicated by **1 or more** of the following:
      - Familial adenomatous polyposis mutation and **ALL** of the following(23)(24):
        - Adenoma previously detected by sigmoidoscopy
        - No colonoscopy in past year
      - Inflammatory bowel disease and **1 or more** of the following(3)(25)(26)(27):

- Dysplasia identified on colonoscopy, and need for follow-up in 3 to 6 months
- Eight years or more since diagnosis, and no colonoscopy in past year
- High risk for colorectal cancer as indicated by **ALL** of the following:
  - Associated clinical conditions as indicated by **1 or more** of the following:
    - First-degree relative with colorectal cancer(28)
    - Prior surveillance findings of **1 or more** of the following:
      - Active inflammation
      - Adenomatous polyps
      - Extensive colitis[D] or pancolitis[E]
      - Pseudo polyps
      - Stricture
  - No colonoscopy in past year
- Low risk for colorectal cancer as indicated by **ALL** of the following:
  - Prior surveillance findings of **1 or more** of the following:
    - Left-sided colitis
    - No endoscopic or histologic evidence of active inflammation
  - No colonoscopy in past 2 years
- Primary sclerosing cholangitis, and no colonoscopy in past year

- Lynch syndrome (ie, hereditary nonpolyposis colorectal cancer) and **ALL** of the following(18)(24):
  - Lynch syndrome diagnosis has been confirmed by positive genetic testing. See Lynch Syndrome - EPCAM, MLH1, MSH2, MSH6, and PMS2 Genes AC for further information.
  - Appropriate at-risk age, as indicated by **1 or more** of the following:
    - Age 25 years or older(29)
    - Age 5 years younger than earliest age of diagnosis of colon cancer in family, or older
  - No colonoscopy in past year(29)
- Surveillance after adenoma or sessile serrated polyp removal, as indicated by **1 or more** of the following(3)(21)(30)(31):
  - Previous surveillance colonoscopy was negative (no new or recurrent adenomas or sessile serrated polyps), and no colonoscopy in past 10 years.(3)
  - Status post removal of 1 or 2 tubular adenomas (or sessile serrated polyps without cytologic dysplasia) less than 1 cm, and no colonoscopy in past 5 years(3)(30)(31)
  - Status post removal of 3 to 10 adenomas (and/or sessile serrated polyps), and no colonoscopy within past 3 years
  - Status post removal of more than 10 adenomas, and no colonoscopy within past 2 years(21)
  - Status post removal of adenoma (or sessile serrated polyp) 1 cm or greater, and no colonoscopy within past 3 years(3)(32)
  - Status post removal of adenoma (or sessile serrated polyp) during flexible sigmoidoscopy(3)
  - Status post removal of adenoma with high-grade dysplasia, or villous or tubulovillous histology, and no colonoscopy within past 3 years(3)(32)
  - Status post removal of sessile serrated polyp with cytologic dysplasia, and no colonoscopy within past 3 years(3)
  - Status post removal of large sessile polyp, or incomplete or piecemeal polypectomy, and no colonoscopy in past 2 months(3)(32)
- Surveillance after colon or rectal cancer removal with curative intent, as indicated by **1 or more** of the following(6)(32)(33)(34)(35):
  - First surveillance colonoscopy 1 year following curative resection, if colonoscopy performed preoperatively(36)
  - First surveillance colonoscopy 3 to 6 months following curative resection, if colonoscopy not performed preoperatively due to obstructing lesion
  - Second surveillance colonoscopy 1 year after first surveillance colonoscopy, if advanced adenoma found on first surveillance colonoscopy
  - Second surveillance colonoscopy 3 years after first surveillance colonoscopy, if no advanced adenoma found on first surveillance colonoscopy
  - Surveillance colonoscopy every 5 years thereafter, if no advanced adenoma found on prior surveillance colonoscopy(4)(34)

− Diarrhea, constipation, or irritable bowel syndrome and **1 or more** of the following(25)(37)(38):N

- Age 50 years or older, with chronic or new-onset bowel disturbance and no prior colorectal cancer screening(41)(43)
- Change in chronic symptoms
- Change in stool caliber
- Persistent (at least 4 weeks) symptoms (eg, constipation, diarrhea, tenesmus) in patient 40 years or older (generally after stool cultures)(44)
- Positive fecal occult blood test(45)(46)
- Rectal bleeding(45)(46)
- Rectal prolapse

- Unexplained weight loss greater than 5% of body weight(45)
- Foreign body in colon(47)N
- Gastrointestinal bleeding and **1 or more** of the following(48)(49)(50):N
  - Bloody diarrhea
  - Change in bowel habits(38)
  - Change in stool caliber
  - Hematochezia (red or maroon blood mixed with stools) and **1 or more** of the following:
    - Age 50 years or older
    - Age younger than 50 years and **1 or more** of the following:
      - Persistent or recurrent bleeding
      - Previous anoscopy or sigmoidoscopy did not reveal a definitive source of bleeding.
  - Iron deficiency anemia
  - Melena, and negative esophagogastroduodenoscopy
  - Positive fecal occult blood test
  - Presence of any colorectal cancer risk factor (eg, familial adenomatous polyposis, family history of colorectal cancer, Lynch syndrome, inflammatory bowel disease)(33)(52)
  - Repeat test for persistent occult bleeding after negative endoscopies(53)
  - Weight loss(54)
- Inflammatory bowel disease and **1 or more** of the following(16)(25)(26)(55):N
  - Confirmation of clinical or radiographic diagnosis(56)
  - Determination of degree of severity or extent of colonic involvement at time of initial diagnosis
  - Evaluation of clinically significant flare
  - Unimproved or worsening symptoms despite therapy
- Iron deficiency (ie, serum ferritin less than 15 ng/mL (33.7 pmol/L)) anemia (ie, hemoglobin less than 12 g/dL (120 g/L) in female or hemoglobin less than 14 g/dL (140 g/L) in male) and **1 or more** of the following(48):N
  - Age 50 years or older
  - GI bleeding
  - Lower abdominal symptoms (eg, diarrhea, constipation)
  - Male patient younger than 50 years
  - No abdominal symptoms and negative upper GI endoscopy
  - Premenopausal female patient with no evidence of abnormal uterine bleeding (ie, menorrhagia or metrorrhagia)
  - Risk factor for colon cancer (eg, family history, previous colonic polyps)
- Ischemic colitis and need for follow-up(57)N
- Pathologic bowel wall thickening detected by other imaging procedure(47)N
- Pseudo-obstruction (acute),[F] and need for treatment, as indicated by **ALL** of the following(58)(62):N
  - Imaging evidence of acute colonic pseudo-obstruction (eg, water-soluble contrast enema, CT colonography)
  - No evidence of perforation or peritonitis
  - No improvement after correction of possible contributing factors (eg, metabolic disorder, infection, medication)
  - No improvement after trial of pharmacologic therapy (eg, neostigmine)[G]
- Sigmoid volvulus and need for treatment(58)(63)(64)(65)N
- Stent placement for malignant large bowel obstruction (eg, colorectal cancer), as indicated by **1 or more** of the following(58)(66)(67)(68)(69)(70):N
  - Palliation for malignant large bowel obstruction
  - Prior to elective colon resection, and **ALL** of the following are present[H]:
    - Left-sided obstruction
    - Patient is poor surgical risk (eg, age older than 70 years, American Society of Anesthesiologists (ASA) Physical Status III or greater).
- Workup of adenocarcinoma, when primary cancer is unknown and results would change management[I](47)N

Alternatives to Procedure

- Alternatives include(3)(6)(9)(76)(77):
  - Abdominal CT scan. See Abdominal/Pelvic CT Scan AC for further information.
  - Contrast Enema. See Contrast Enema: Single-Contrast, Double-Contrast, or Therapeutic AC for further information.
  - CT colonography.(4)(10)(78)(79)(80)(81) See Colonography, CT (Virtual Colonoscopy) AC for further information.
  - Fecal DNA testing. See Fecal DNA Testing AC for further information.
  - Fecal immunochemical test for blood(1)(82)
  - Fecal occult blood testing(77)(83)(84)
  - Flexible sigmoidoscopy.(10)(85)(86) See Sigmoidoscopy, Flexible AC for further information.
  - Nuclear medicine gastrointestinal blood loss study. See Gastrointestinal Blood Loss Study AC for further information.

Evidence Summary

Background

Colonoscopy allows for direct visualization of the colonic mucosa throughout the entire colon; if polyps are discovered, polypectomy can also be performed during the procedure. It is invasive and carries risks including perforation and bleeding. Studies have reported an overall complication rate of 2.9 to 5.0 per 1000 endoscopies and a perforation rate of 0.9 to 1.8 per 1000 endoscopies.(1) **(EG 2)**

Criteria

For colon cancer screening, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Colonoscopy is one of several procedures to detect colorectal cancer endorsed by US and international guidelines.(3)(6)(8)(9)(10) **(EG 2)** Colonoscopy should start at age 45 years for African Americans, age 50 years for other average-risk adults, and earlier for those at higher risk due to high-risk family history, hereditary inflammatory bowel disease, or previous cancerous or precancerous lesions.(8)(11) **(EG 2)** A population-based case control study showed that colonoscopy in the preceding 10 years was associated with a 77% reduced risk for colorectal cancer.(12) **(EG 2)** Analysis of data from 88,900 patients (from 2 prospective cohort studies) followed over a 22-year period found that a negative colonoscopy was associated with reduced incidence of cancer in the proximal and distal colorectum. Screening colonoscopy and sigmoidoscopy were associated with reduced mortality from colorectal cancer, and colonoscopy was associated with reduced mortality from proximal colon cancer. The authors estimated that 40% of all colorectal cancers that developed during follow-up would have been prevented if all study participants had undergone colonoscopy.(13) **(EG 2)** A nested case control study that included 471 patients and 509 matched controls from 4 US health plans found that screening with colonoscopy in average-risk persons was associated with an approximately 70% reduced risk for late-stage colorectal cancer, including right-sided colon cancer.(14) **(EG 2)** While a systematic review found no direct evidence that cancer screening and surveillance in patients with inflammatory bowel disease prolongs survival, there is indirect evidence via case control studies and other data.(15) **(EG 2)** Studies suggest that colonoscopic surveillance increases the probability of discovering cancer at an earlier stage and that 5-year survival is increased, although the evidence quality is low.(16) **(EG 2)** A series of 259 patients with colitis due to Crohn disease who underwent surveillance colonoscopy every 1 to 2 years found that 7% of patients had dysplasia or cancer on initial screening, and there was a 25% risk of detecting dysplasia or cancer by the 10th colonoscopy.(17) **(EG 2)** A prospective multicenter cohort study included 1126 patients with Lynch syndrome who underwent 3474 colonoscopies; the study supported annual colonoscopies for Lynch syndrome patients because colorectal cancers detected by follow-up colonoscopies had significantly lower tumor stages than those detected by symptoms.(18) **(EG 2)** A prospective cohort study of 2602 patients who had adenomas removed by colonoscopy, with median follow-up of 15.8 years, showed that, when compared with the general population, colonoscopic removal of adenomatous polyps was associated with a 53% reduction in mortality from colorectal cancer.(7) **(EG 2)** Cohort analysis of 40,800 patients who underwent colorectal adenoma removal by colonoscopy found, at a median follow-up of 7.7 years, that adenoma removal was associated with a 14% risk reduction in colorectal cancer mortality in men, but not in women. As compared with the general population, colorectal cancer mortality was reduced by 25% for patients who had low-risk adenomas removed, but was increased by 16% for those with high-risk adenomas.(19) **(EG 2)**

For diarrhea, constipation, or irritable bowel syndrome, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** The diagnosis of irritable bowel syndrome is based on symptoms defined in the Rome IV criteria, which have sensitivity of 62.7% and specificity of 97.1%. Criteria include symptom onset of at least 6 months, active symptoms for at least 3 months prior to consideration of diagnosis, and abdominal pain for at least 1 day per week for the past 3 months associated with at least 2 additional symptoms, including pain related to defecation, change in bowel habits or stool form.(39)(40) **(EG 2)** Although testing is generally not indicated for diagnosis of irritable bowel syndrome, colonoscopy is recommended for patients age 50 years or older for the purpose of colorectal cancer screening.(37)(41) **(EG 2)** Colonoscopy is also recommended to rule out other organic disease when suspected irritable bowel syndrome is associated with "alarm symptoms" such as unexplained weight loss, severe diarrhea, or significant rectal bleeding.(41)(42) **(EG 2)** Evidence-based specialty society guidelines state that there is insufficient evidence to support the use of colonoscopy for patients with constipation in the absence of alarm features (eg, rectal bleeding, anemia, weight loss, family history of colon cancer, age of onset older than 50 years).(37)(38) **(EG 2)**

For foreign body in colon, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** An attempt at colonoscopic removal of a foreign body of the colon is recommended in order to avoid possible surgical intervention.(47) **(EG 2)**

For gastrointestinal bleeding, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** For lower gastrointestinal bleeding, colonoscopy is the preferred test for patients who have a high probability of a colonic source. Advantages over other interventions include the ability to identify the source of bleeding in the absence of active bleeding, to achieve hemostasis when active bleeding is present, and to prevent recurrent bleeding. Studies demonstrate that colonoscopy is able to establish a diagnosis in 74% to 100% of patients, as compared with 40% to 70% for radionuclide scanning and 35% to 72% for angiography.(50) **(EG 2)** A review article notes that occult gastrointestinal bleeding evaluated with both upper endoscopy and colonoscopy identified a colorectal source of bleeding in 20% to 30% of patients.(51) **(EG 2)** Specialty society guidelines recommend colonoscopy for the evaluation of occult lower gastrointestinal bleeding; colonoscopy should be performed for melena if esophagogastroduodenoscopy fails to reveal a source of bleeding. Colonoscopy is recommended for the evaluation of hematochezia in patients age 50 years or older or in patients with any colorectal cancer risk factors; colonoscopy is recommended if flexible sigmoidoscopy does not reveal a definitive source of bleeding.(48)(49) **(EG 2)**

For inflammatory bowel disease, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Colonoscopy is recommended for confirmation of a suspected diagnosis, determination of the extent and severity of disease, investigation of persistent or worsening symptoms, and surveillance for dysplasia and colorectal cancer for patients with longstanding disease or associated primary sclerosing cholangitis.(16)(25)(26) **(EG 2)** An evidence-based pediatric specialty guideline supports the use of colonoscopy as part of the initial workup for all children with suspected inflammatory bowel disease.(55) **(EG 2)** Endoscopic and histologic remission generally lag behind clinical response to treatment. Studies suggest that endoscopic remission is a predictor of later symptomatic and clinical outcomes.(26) **(EG 2)**

For iron deficiency anemia, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Colorectal cancer is more prevalent in patients with iron deficiency anemia as compared with iron deficient nonanemic patients.(48) **(EG 2)** Other common endoscopic findings in patients with iron deficiency anemia include adenomas, angiodysplasia, and inflammatory bowel disease.(48) **(EG 2)**

For ischemic colitis and need for follow-up, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** An observational study of 112 patients with ischemic colitis diagnosed by colonoscopy and biopsy found that colonoscopy resulted in a change in treatment plan (additional medical vs surgical treatment) in 50% of cases, which increased to 66% when the indication was urgent. Serial colonoscopy and assessment of clinical status were helpful in determining the timing of possible subsequent surgical intervention.(57) **(EG 2)**

For pathologic bowel wall thickening detected by other imaging procedure, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** Colonoscopy is indicated for further assessment of pathologic bowel wall thickening that is detected by x-ray, ultrasound, CT scan, or MRI.(47) **(EG 2)**

For pseudo-obstruction (acute), evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Colonoscopic decompression is recommended for patients with acute colonic pseudo-obstruction without evidence of perforation or peritonitis after failure of correction of contributing factors (eg, metabolic disorder, infection, medication) and a trial of pharmacologic therapy (overall long-term response rate of 31% to 100%). Success rates for colonoscopic decompression range from 73% to 88%.(58)(62) **(EG 2)**

For sigmoid volvulus, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Colonoscopic decompression, as an alternative to acute surgical intervention, is recommended for the evaluation and initial treatment of suspected sigmoid volvulus. Success rates for decompression range from 70% to 80% for primary volvulus and 40% to 60% for secondary volvulus, with a recurrence rate of 18% to 90%. Surgical resection is generally recommended after colonoscopic detorsion.(58)(63)(64) **(EG 2)**

For stent placement for obstructing neoplasm, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Cohort studies demonstrate successful palliation of malignant colon and rectal obstruction through the endoscopic placement of metal stents.(71) **(EG 2)** A prospective randomized trial of 22 patients with stage IV unresectable rectosigmoid cancer and symptoms of chronic subacute obstruction found that endoscopic expandable stent placement, as compared with diverting proximal colostomy, had equivalent mean long-term survival of approximately 290 days and was better accepted by patients and their families.(72) **(EG 1)** A meta-analysis of trials of patients with malignant large bowel obstruction found that, when attempted, endoscopic stent insertion was successful 93% of the time.(73) **(EG 1)** Other colonoscopic modalities for palliative relief of malignant obstruction include laser ablation, argon plasma coagulation, and transanal colonoscopic tube decompression.(58)(74) **(EG 2)** A specialty society guideline and review article indicate that colonic stent placement is an alternative to emergency surgery in higher-risk patients with left-sided malignant colonic obstruction as a bridge to elective surgery; surgical resection is the preferred treatment for malignant colonic obstruction.(66)(67) **(EG 2)**

For workup of adenocarcinoma, when primary cancer is unknown and results would change management, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Colonoscopy is recommended for cancer of unknown origin that is pathologically consistent with a colon primary and would lead to the use of systemic therapy or potentially curative surgery.(47)(75) **(EG 2)**

Inconclusive or Non-Supportive Evidence

For diverticulitis (acute, uncomplicated), evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review and meta-analysis of 8 studies (with a total of 1796 patients) evaluating the efficacy of routine colonoscopy after an episode of acute uncomplicated diverticulitis (as confirmed by CT or ultrasound) to exclude an underlying malignancy found that the pooled prevalence of colorectal cancer and advanced adenoma were 1.5% and 3.8%, respectively. The authors concluded that, although the studies were of moderate methodological quality, current evidence does not support the use of routine colonoscopy after an episode of acute uncomplicated diverticulitis.(2) **(EG 1)**

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Footnotes

[A] Average risk includes patients of age 50 years or older (or African Americans of age 45 years or older) without a personal history of adenoma, sessile serrated polyp, or colorectal cancer, without inflammatory bowel disease, and without a family history of colorectal cancer.(3)(10) [A in Context Link 1]

[B] First-degree relatives consist of male or female parents, siblings, or children.(22) [B in Context Link 1, 2, 3, 4]

[C] Second-degree relatives consist of aunts, uncles, grandparents, half-siblings, cousins, great-grandparents, nieces, and nephews.(3) [C in Context Link 1]

[D] Extensive colitis describes inflammation extending from the rectum to beyond the splenic flexure.(26) [D in Context Link 1]

[E] Pancolitis describes inflammation involving the entire colon.(26) [E in Context Link 1]

[F] Acute colonic pseudo-obstruction, also known as Ogilvie syndrome, is characterized by massive colonic dilation in the absence of mechanical obstruction.(58) Chronic pseudo-obstruction is generally treated with nutritional support, pharmacotherapy, or surgery (including transplant in selected cases), with colonoscopic decompression playing a limited role.(59)(60)(61) [F in Context Link 1, 2]

[G] Relative contraindications to neostigmine include a history of myocardial infarction, bradycardia, acidosis, asthma, peptic ulcer disease, serum creatinine greater than 3 mg/dL (265 micromoles/L), and therapy with beta-blockers.(58)(62) [G in Context Link 1]

[H] In patients with potentially curable left-sided colon cancer, temporary stent placement as a bridge to elective surgery is associated with lower complication rates, reduced length of stay, and lower colostomy rates compared with emergency surgery; it may also provide time to stabilize the patient and address underlying comorbidities.(58)(66) [H in Context Link 1]

[I] Colonoscopy should be used only when making a specific diagnosis that will alter treatment outcome. [I in Context Link 1]

Codes

CPT®: 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398 [Hide]

HCPCS: G0105, G0121

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Esophagogastroduodenoscopy (EGD), UGI Endoscopy

MCG Health
Ambulatory Care
22nd Edition

ACG: A-0203 (AC)
Link to Codes

Clinical Indications for Procedure

- Esophagogastroduodenoscopy (UGI endoscopy) may be indicated for **1 or more** of the following:
  - Achalasia (eg, onabotulinumtoxinA injection, balloon dilation)(3)(4)(5)N
  - Atypical chest pain, after cardiac disease has been ruled out(6)(8)N
  - Barrett esophagus[A] and **1 or more** of the following(9)(12)(13)(14)(15)(16):N
    - Endoscopic resection and/or ablation (ie, cryoablation, radiofrequency, or photodynamic therapy) for high-grade dysplasia (Tis) or mucosal tumors that do not invade submucosa (T1a)
    - Low-grade dysplasia on previous endoscopy: repeat UGI endoscopy at 6 months to reconfirm diagnosis, then annually(12)(23)
    - Nondysplastic Barrett esophagus (metaplastic columnar or glandular epithelium) on previous endoscopy: UGI endoscopy with 4-quadrant biopsy every 3 to 5 years(12)(24)
    - Postendoscopic resection and/or ablation (ie, cryoablation, radiofrequency or photodynamic therapy) surveillance, as indicated for **1 or more** of the following(9)(12)(25)(26):
      - High-grade dysplasia (Tis): every 6 months for 1 to 2 years, then annually for 3 more years
      - Mucosal tumors that do not invade submucosa (T1a): every 3 months for year 1, every 4 to 6 months for year 2, then annually for 3 more years
  - Caustic ingestion with symptoms(2)(27)N
  - Crohn disease and suspected involvement of **1 or more** of the following(28)(29)(30):N
    - Esophagus
    - Stomach
    - Duodenum
  - Duodenal disease, suspected, and need for examination and biopsy (eg, celiac disease, neoplastic lesion)(2)(31)(32)(33)(34)N
  - Dyspepsia and **1 or more** of the following(1)(35):N
    - Dysphagia or odynophagia[B](2)
    - Failure of medical therapy (eg, poor response to H2-receptor antagonists, proton pump inhibitors)(2)
    - Family history of upper GI cancer in first-degree relative(37)(38)
    - History of gastric surgery
    - Iron deficiency anemia
    - Persistence for 3 months or longer
    - Use of NSAIDs
    - Vomiting(2)(38)
    - Weight loss of more than 3 kg (6.6 lb) since symptoms began
  - Dysphagia and **1 or more** of the following(1)(36)(39):N
    - Bleeding associated with any swallowing problem
    - Eosinophilic esophagitis, suspected, and need for biopsy(46)(47)
    - Foreign body, known or suspected(2)(40)
    - Malignant compression and need for stent placement(48)(49)
    - Mechanical obstruction, suspected, due to clinical signs or results of radiographic testing (eg, Schatzki ring, vascular ring, esophageal stricture, ingested foreign body, gastric outlet obstruction)(2)(9)(40)(43)(44)
    - Swallowing problems that are persistent or recurrent(2)(6)(44)
    - Transient obstruction, with repeated episodes
  - Esophageal or gastric cancer and need for endoscopic treatment, as indicated by **1 or more** of the following(2)(9)(50):N

- Ablation of polyp, tumor, or other lesions(38)(54)
- Dilation of malignant stricture(39)
- Endoscopic mucosal resection or submucosal dissection of esophageal or esophagogastric junction cancer (high-grade dysplasia, carcinoma limited to lamina propria or muscularis mucosa, or superficial submucosa carcinoma without lymphovascular invasion)(9)(25)(51)(55)
- Endoscopic mucosal resection or submucosal dissection of gastric carcinoma (carcinoma in situ or well-differentiated carcinoma invading lamina propria or muscularis mucosa that is 2 cm or less and without evidence of ulceration, lymph node metastases, or lymphovascular invasion)(50)(56)(57)(58)
- Surveillance for esophageal or esophagogastric junction cancer postendoscopic resection and/or ablation (ie, cryoablation, radiofrequency or photodynamic therapy), as indicated by **1 or more** of the following(9)(25)(51)(55):
    - High-grade dysplasia (Tis): every 3 months for year 1, then every 6 months for year 2, then annually
    - Carcinoma limited to lamina propria or muscularis mucosa (T1a): every 3 months for year 1, then every 6 months for year 2, then annually
    - Superficial submucosa carcinoma (T1b) without lymphovascular invasion: every 3 months for year 1, every 4 to 6 months for year 2, then annually
- Stent placement for obstruction due to intrinsic or extrinsic compression(9)(50)(59)(60)(61)(62)(63)(64)
- Tumor debulking or ablation (eg, electrocautery, laser, chemical)(44)
- UGI endoscopy with biopsy for esophageal cancer approximately 5-8 weeks after completion of preoperative chemotherapy, radiation therapy(9)

− Esophageal or gastric cancer screening in patient at increased risk, as indicated by **1 or more** of the following(9)(50)(65)(66): N

- History of achalasia: possible screening 15 years after symptom onset
- History of caustic injury to esophagus and **1 or more** of the following:
    - Development of new UGI symptoms
    - Routine follow-up at 15 to 20 years after caustic ingestion, then repeated every 1 to 3 years
- History of familial adenomatous polyposis: Surveillance for duodenal, gastric, or periampullary cancer starts at age 25 to 30 years and is repeated based upon duodenal polyp burden; consider baseline endoscopy earlier if colectomy performed before 20 years of age.(65)
- History of gastric adenomatous polyps: Surveillance endoscopy is indicated 1 year after removal; if negative, then at 3-year to 5-year intervals.(2)
- History of gastric carcinoid tumor: Screening frequency is individualized.
- History of gastric resection and **1 or more** of the following:
    - Development of any new UGI symptoms
    - Routine follow-up at 15 to 20 years after resection, with multiple biopsies from anastomosis and gastric remnant
- History of hereditary cancer predisposition syndrome, as indicated by **1 or more** of the following(9):
    - Bloom syndrome: Surveillance after 20 years of age
    - Familial Barrett esophagus: Surveillance for patient who presents with GERD
    - Fanconi anemia: consider surveillance in patients identified with Fanconi anemia
    - Tylosis[C]: Surveillance every 1 to 3 years, beginning at age 20 years(9)(68)
- History of hereditary diffuse gastric cancer: Surveillance every 6 months for mutation carriers who do not elect to undergo gastrectomy
- History of juvenile polyposis syndrome: Surveillance starting at age 15, repeat annually if polyps are found, and repeat every 2 to 3 years if no polyps found(65)
- History of Lynch syndrome (ie, hereditary nonpolyposis colorectal cancer): Surveillance is individualized.[D]
- History of pernicious anemia or atrophic gastritis: Single endoscopy is indicated.(2)
- History of Peutz-Jeghers syndrome: Surveillance starts in late teens and continues every 2 to 3 years.(65)

− Esophageal varices and **1 or more** of the following(69)(70)(71)(72): N

- Need for ligation or sclerosis of known esophageal varices(73)(74)
- Screening for patient at high risk (eg, known chronic liver disease)

− Gastroesophageal reflux disease symptoms and **1 or more** of the following(24)(47)(75)(76): N

- Anemia
- Dysphagia
- Epigastric mass on examination
- Failure of medical therapy (eg, poor response to empiric twice-daily proton pump inhibitor for 4 to 8 weeks)(2)
- Gastrointestinal bleeding
- History of esophageal stricture and recurrent dysphagia
- Male 50 years or older with 5 years or more of gastroesophageal reflux disease symptoms and **1 or more** of the following:
    - Elevated BMI
    - Hiatal hernia
    - Intra-abdominal distribution of fat
    - Nocturnal reflux symptoms
    - Tobacco use
- Recurrent vomiting

- Severe erosive esophagitis, known, and need for follow-up after 8 weeks of proton pump inhibitor therapy
- Weight loss of more than 3 kg (6.6 lb) since symptoms began

− Gastrointestinal bleeding, as indicated by **1 or more** of the following(1)(2)(77)(78):N
- Blood in stools, and negative colonoscopy(75)(84)
- Blood in stools, and positive nasogastric tube aspirate(82)
- Hematemesis(79)(81)(85)
- Lower gastrointestinal bleeding, with indeterminate colonoscopy, and clinical presentation suggests UGI source (eg, dyspepsia, reflux, NSAID use, peptic ulcer disease, liver disease, alcohol abuse)
- Melena(81)
- Persistent occult bleeding after negative endoscopies, and need for repeat test(86)
- Recurrent bleeding evident, with history of UGI bleeding or ulcer(79)

− History of UGI bleeding or ulcer, and results may change management, as indicated by **1 or more** of the following(2):N
- Long-term anticoagulation planned
- Long-term NSAID therapy planned
- Organ transplant planned

− Iron deficiency anemia and **1 or more** of the following(1)(2)(86):N
- Dyspepsia
- Patient is male or postmenopausal female.
- Source of blood loss not found on colonoscopy

- Nausea and vomiting, unexplained(1)(2)N
- Odynophagia[B](2)N

− Peptic ulcer disease, as indicated by **1 or more** of the following(87):N
- Before treatment for suspected ulcer, with **1 or more** of the following:
  - Blood in stool
  - Definitive diagnosis of *Helicobacter pylori* infection required because of **ALL** of the following:
    - Empirical trial of treatment inappropriate because of history of adverse drug reactions
    - Results of noninvasive tests for *Helicobacter pylori* negative or indeterminate
  - History of UGI surgery, gastrointestinal tract anomalies, or complicated antral, pyloric, or duodenal ulcer with scarring or gastric outlet obstruction
  - Iron deficiency anemia
- Gastric ulcer and **1 or more** of the following:
  - Dysplasia on initial biopsy
  - Family history of gastric cancer
  - Ulcer appearance on initial endoscopy large or suspicious for malignancy
  - Ulcer appearance on UGI barium study suspicious for malignancy(2)
  - Ulcer not associated with NSAID usage(89)
- After treatment of duodenal ulcer, with **1 or more** of the following:
  - Incomplete clinical response to treatment
  - Ulcer complicated by bleeding or obstruction
  - Ulcer initially greater than 2 cm in diameter

- Weight loss, unexplained(2)N

Alternatives to Procedure

- Alternatives include:
  - Abdominal CT scan. See Abdominal/Pelvic CT Scan AC for further information.
  - Abdominal ultrasound. See Abdominal Ultrasound AC for further information.
  - Capsule endoscopy.(85)(90)(91)(92) See Capsule Endoscopy AC for further information.
  - Contrast swallowing evaluation. See UGI Contrast Studies: Esophagography, UGI Study, Small Bowel Follow-Through, and Swallowing Evaluation AC for further information.
  - Esophageal transit scintigraphy. See Esophageal Transit Scintigraphy AC for further information.
  - Gastric emptying study. See Gastric Emptying Study (Gastric Scintigraphy) AC for further information.
  - Gastrointestinal blood loss study. See Gastrointestinal Blood Loss Study AC for further information.
  - UGI contrast studies.(1) See UGI Contrast Studies: Esophagography, UGI Study, Small Bowel Follow-Through, and Swallowing Evaluation AC for further information.

Evidence Summary

Background

Esophagogastroduodenoscopy, also known as UGI endoscopy, is performed by passing a flexible endoscope through the nose or mouth in order to view the esophagus, stomach, and duodenum.(1)(2) **(EG 2)** In elective cases, it is performed in an outpatient setting. (1) **(EG 2)** It allows direct visualization of the mucosa and permits directed biopsy and endoscopic therapy.(1)(2) **(EG 2)**

Criteria

For achalasia, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** A specialty society guideline supports the use of UGI endoscopy for management of achalasia (eg, botulinum toxin injection, balloon dilation).(3) **(EG 2)** OnabotulinumtoxinA has a 1-month response rate of greater than 75%; however, approximately 50% of patients relapse and require repeat injections at 6 to 24-month intervals. Studies of balloon dilation report therapeutic success in up to 90% of patients, with relapse occurring in about 1/3 of patients over a 4 to 6-year period; repeat dilation can achieve long-term symptomatic remission in the majority of patients.(4)(5) **(EG 2)** Both onabotulinumtoxinA injection and balloon dilation are inferior to surgical myotomy, which is the treatment of choice for younger patients and those without contraindications to surgical therapy.(6)(7) **(EG 2)**

For atypical chest pain, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** Esophageal chest pain closely mimics cardiac chest pain, which should be the primary consideration and excluded or treated before UGI endoscopy is performed.(8) **(EG 2)** Up to 65% of patients with achalasia will present with chest pain.(5) **(EG 2)**

For Barrett esophagus-associated high-grade dysplasia or mucosal tumors that do not invade submucosa, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Specialty society guidelines recommend UGI endoscopy every 3 to 5 years for nondysplastic Barrett esophagus, or at 6 months to reconfirm a diagnosis of low-grade dysplasia and then annually. Endoscopic mucosal resection and/or ablation (ie, cryoablation, radiofrequency, or photodynamic therapy) are preferred alternatives to esophagectomy for Barrett esophagus-associated high-grade dysplasia (Tis) or mucosal tumors that do not invade the submucosa (T1a). After endoscopic resection for these conditions, surveillance endoscopy varies with the tumor classification (eg, Tis, T1a).(9)(12)(17) **(EG 2)** A review of studies of endoscopic mucosal resection for Barrett esophagus with high-grade dysplasia reported complete remission rates of 88% to 100%.(13)(18) **(EG 2)** A systematic review and meta-analysis of 37 studies (521 patients) evaluating the efficacy of endoscopic treatments for low-grade dysplasia associated with Barrett esophagus found pooled rates of complete eradication of intestinal metaplasia and dysplasia of 68% and 89%, respectively; the pooled incidence of progression to cancer was 3.9 per 1000 patient-years.(19) **(EG 1)** Studies of 50 or more patients with low-grade dysplasia followed for 2 to 7 years found that the incidence of cancer ranged from 1% to 39%.(20) **(EG 2)** An observational study of 90 Barrett esophagus patients who underwent endoscopic mucosal resection found, at follow-up of at least 36 months, that 90% of patients achieved complete eradication. Upon additional mean follow-up of 65 months, 40% of these patients developed recurrent Barrett esophagus and 6% developed recurrent neoplasia, all of whom were retreated and had negative biopsies on follow-up endoscopy.(21) **(EG 2)** Consensus statements from an international multidisciplinary group that performed a comprehensive literature review recommend that a high-resolution endoscope be used for surveillance of patients with Barrett esophagus and that 4-quadrant biopsies are needed to exclude synchronous neoplastic lesions. Moreover, endoscopic mucosal resection of high-grade dysplasia and subsequent ablation has been found to be superior to surveillance alone and can result in complete remission of neoplasia in 80% to 100% of cases.(12)(22) **(EG 2)**

For caustic ingestion, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** A specialty guideline supports the use of UGI endoscopy for assessment of acute injury after caustic ingestion.(2) **(EG 2)** In a multicenter observational study of 162 children of median age 36.9 months, multivariate analysis showed that the presence of symptoms was significantly associated with severe esophageal lesions (odds ratio of 2.3), leading to the conclusion that endoscopy is mandatory in symptomatic patients.(27) **(EG 2)**

For Crohn disease, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A systematic review of 20 studies of 2511 patients with Crohn disease who underwent gastroduodenal biopsy reported a prevalence of upper gastrointestinal involvement of 34%.(29) **(EG 1)** According to a specialty society guideline, routine UGI endoscopy is not recommended for all patients suspected of having Crohn disease because when the UGI tract is involved in Crohn disease, disease is usually present in the terminal ileum, colon, or perianal area.(28) **(EG 2)** Similarly, routine UGI endoscopy is not recommended for diagnostic assessment of suspected inflammatory bowel disease in children and young adults.(30) **(EG 2)** Patients with symptomatic duodenal strictures due to Crohn disease may benefit from endoscopic balloon dilation.(28) **(EG 2)**

For duodenal disease and need for examination and biopsy (eg, celiac disease, neoplastic lesion), evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Specialty society guidelines support the use of UGI endoscopy for biopsy confirmation of suspected celiac disease and suspected neoplastic lesion.(2)(31)(33) **(EG 2)** An observational study of 47 pediatric patients with suspected celiac disease who underwent duodenal biopsy found that the diagnosis was confirmed in 89% of cases.(32) **(EG 2)**

For dyspepsia, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** UGI endoscopy should be performed in patients with alarm features (eg, weight loss, iron deficiency anemia) and is a useful diagnostic tool if empiric treatment does not resolve symptoms.(1) **(EG 2)** A retrospective review of 2000 consecutive patients who underwent UGI endoscopy for UGI symptoms showed that a significantly higher percentage of patients with alarm symptoms (eg, dysphagia, vomiting, anemia, weight

loss, persistent symptoms) had abnormal findings as compared with patients without alarm symptoms (65% vs 42%, respectively).(35) **(EG 2)**

For dysphagia, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** UGI endoscopy is indicated to rule out esophageal carcinoma in patients with symptoms of bleeding and dysphagia.(9)(39) **(EG 2)** Specialty society guidelines support the use of UGI endoscopy for foreign body removal, confirmation and histologic diagnosis of suspected upper tract stricture or obstruction as demonstrated by radiographic testing, and upper GI symptoms that are persistent or recurrent (eg, dysphagia due to suspected achalasia, benign or malignant stricture, esophageal reflux).(2)(40) **(EG 2)** An observational study of 115 pediatric patients who underwent endoscopic removal of a foreign body of the esophagus found that surgery was required in less than 1% of patients.(41) **(EG 2)** When mechanical obstruction is suspected as a cause of dysphagia, UGI endoscopy is a useful initial diagnostic test because it permits immediate biopsy with or without dilation of strictures, masses, or rings.(1)(36)(39) **(EG 2)** Database analysis of patients undergoing dilation for a symptomatic esophageal ring found that 65% of the patients had symptoms of dysphagia.(42) **(EG 2)** A small observational study of children with a suspected vascular ring found that there was 85% agreement between endoscopic and surgical findings.(43) **(EG 2)** Recurrent symptoms can occur in up to 65% of patients 1 year after treatment with onabotulinumtoxinA injection for achalasia.(6) **(EG 2)** Recurrent dysphagia can occur in up to 40% of patients who had stent placement for malignant stricture due to stent migration, tumor growth, or food obstruction.(44) **(EG 2)** A specialty society guideline states that a biopsy that shows a peak eosinophil level of 15 or more cells per high-powered field is required to make a diagnosis of eosinophilic esophagitis in patients who have symptoms of esophageal dysfunction, including dysphagia.(45)(46) **(EG 2)**

For esophageal or gastric cancer and need for endoscopic treatment, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** A specialty society guideline supports the use of UGI endoscopy for ablation or removal of selected polyps, tumors, or other lesions; for dilation of malignant strictures; for palliative stent placement in patients with stenosing neoplasms or malignant esophageal fistula; or for tumor debulking or ablation (eg, electrocautery, laser, chemical) of stenosing esophageal neoplasms.(2)(9)(50) **(EG 2)** An expert consensus guideline supports the use of endoscopic mucosal resection or submucosal dissection, and/or ablation (ie, cryoablation, radiofrequency, or photodynamic therapy) of esophageal or esophagogastric junction cancer (high-grade dysplasia (Tis), carcinoma limited to the lamina propria or muscularis mucosa (T1a), or superficial submucosa carcinoma (T1b) without lymphovascular invasion). After endoscopic resection, the frequency of surveillance endoscopy varies depending upon the tumor classification (eg, Tis, T1a, T1b).(9) **(EG 2)** A retrospective matched cohort study that included 114 patients with mucosal esophageal adenocarcinoma found that both en bloc esophagectomy and endoscopic resection are effective when done in high-volume centers; however, esophagectomy was associated with higher morbidity and risk for procedure-related mortality, while endoscopic resection was associated with a higher recurrence rate that mandated thorough follow-up.(51) **(EG 2)** A systematic review and meta-analysis of 19 studies (6118 patients) did not identify any randomized controlled trials comparing endoscopic resection with gastrectomy for early gastric cancer; however, it found that there was no significant difference in 3 and 5-year disease-free survival or 5 and 10-year overall survival between the procedures. Endoscopic resection was associated with increased rates of local recurrence and metachronous lesions.(52) **(EG 1)** An expert consensus guideline supports the use of endoscopic mucosal resection or submucosal dissection for gastric cancer (carcinoma in situ or well-differentiated carcinoma invading the lamina propria or muscularis mucosa that is 2 cm or less and without evidence of ulceration, lymph node metastases, or lymphovascular invasion).(50) **(EG 2)** A systematic review of stents for malignant gastric outlet obstruction found that the postprocedure clinical success rate was 83% with a mean patency time of 115 days.(53) **(EG 2)**

For esophageal or gastric cancer screening, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** An evidence-based specialty society guideline recommends consideration of periodic surveillance with UGI endoscopy and biopsies for patients with hereditary cancer predisposition syndromes (eg, tylosis, familial Barrett esophagus, Bloom syndrome, Fanconi anemia).(9) **(EG 2)** Uncontrolled studies and database analysis suggest a reduction in mortality with screening patients at increased risk for gastric cancer.(38)(67) **(EG 2)** The accuracy of UGI endoscopy with adequate biopsies for the detection and diagnosis of early gastric cancer in patients at increased risk has been reported to be between 90% and 96%, making it the gold standard for gastric cancer diagnosis.(38) **(EG 2)**

For esophageal varices, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** Specialty society guidelines support the use of UGI endoscopy for patients with cirrhosis in order to document and treat esophageal varices.(69)(70) **(EG 2)**

For gastroesophageal reflux disease symptoms, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** Specialty groups recommend UGI endoscopy for certain patients with gastroesophageal reflux disease, including those who have alarm symptoms, those who have failed a trial of medical therapy, and those who require reassessment after treatment for severe erosive esophagitis; however, it was noted that no direct evidence shows that screening and surveillance endoscopy programs decrease death from adenocarcinoma of the esophagus.(24)(75) **(EG 2)** Cohort and case control studies have suggested that esophageal cancer discovered through endoscopic screening and surveillance is associated with longer survival time than esophageal cancer presenting symptomatically; however, these studies are limited by lead time and length bias.(24) **(EG 2)**

For gastrointestinal bleeding, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** UGI endoscopy is indicated for evaluation of blood in stools and occult fecal blood if no source is found on colonoscopy because up to 41% of patients with fecal occult blood can have significant findings (eg, peptic ulcer disease, esophagitis) on UGI endoscopy even in the absence of symptoms.(75) **(EG 2)** For hematemesis, early UGI endoscopy (within 24 hours of presentation) is recommended for risk

stratification; low-risk patients may be safely discharged promptly after UGI endoscopy, and patients with high-risk stigmata may require hemostatic therapy.(73)(77)(79)(80) **(EG 2)** For melena, UGI endoscopy should be the initial diagnostic test because an upper tract source is the most likely site of bleeding.(81)(82)(83) **(EG 2)**

For a history of UGI bleeding or ulcer, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A specialty society guideline supports the use of UGI endoscopy for the identification of UGI pathology that may modify planned management (eg, patient is a transplant candidate, prior to initiation of long-term anticoagulation or NSAID therapy for arthritis).(2) **(EG 2)**

For iron deficiency anemia, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A specialty society guideline supports the use of UGI endoscopy for evaluation of iron deficiency anemia when the clinical situation suggests a UGI source, and a source of bleeding is not found on colonoscopy.(2) **(EG 2)**

For nausea and vomiting (unexplained), evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A specialty society guideline supports the use of UGI endoscopy for persistent vomiting of unknown etiology.(2) **(EG 2)**

For odynophagia, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A specialty society guideline supports the use of UGI endoscopy for the evaluation of patients with odynophagia.(2) **(EG 2)**

For peptic ulcer disease, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** UGI endoscopy is the most sensitive and specific technique for examining the upper GI tract; approximately 8% of gastric ulcers that appear to be benign on radiography are malignant on endoscopy.(87) **(EG 2)** UGI endoscopy is a useful diagnostic tool if treatment for diagnosed *Helicobacter pylori* infection results in an incomplete clinical response.(87)(88) **(EG 2)** A retrospective review of 2000 consecutive patients who underwent UGI endoscopy for evaluation of UGI symptoms showed that a significantly greater percentage of patients with alarm symptoms (including gastrointestinal bleeding and anemia) had abnormal findings (including gastric inflammation, ulcer, and cancer) as compared with patients without alarm symptoms (65% vs 42%, respectively).(35) **(EG 2)**

For weight loss (unexplained), evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A specialty society guideline supports the use of UGI endoscopy for upper abdominal symptoms associated with unexplained weight loss.(2) **(EG 2)**

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Footnotes

[A] Barrett esophagus is the replacement of the normal squamous epithelium of the esophagus that is damaged by gastroesophageal reflux disease with metaplastic columnar or glandular epithelium that is predisposed to esophageal adenocarcinoma.(9)(10)(11) [A in Context Link 1, 2]

[B] Odynophagia is the sensation of pain on swallowing.(36) [B in Context Link 1, 2]

[C] Tylosis is a rare autosomal dominant syndrome associated with increased risk of esophageal squamous cell carcinoma.(9)(68) [C in Context Link 1]

[D] For Lynch syndrome, there is no clear evidence to support screening for gastric, duodenal, or small bowel cancer. Selected individuals or families or those of Asian descent may consider UGI endoscopy with extended duodenoscopy every 3 to 5 years, beginning at age 30 to 35 years.(65) [D in Context Link 1]

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Link to Codes

Clinical Indications for Procedure

- Lingual frenuloplasty or frenotomy (frenectomy or frenulectomy) may be indicated for **1 or more** of the following(1)(2):
  - Difficulty in latching during breast-feeding if due to ankyloglossia, as determined by certified lactation consultant[A](6)(7)(8)(9)N
  - Recurrent nipple pain from breast-feeding if due to ankyloglossia, as determined by certified lactation consultant[A](8)(9)(11)(14)N

Alternatives to Procedure

- Alternatives include(4)(6):
  - Lactation consultation for breast-feeding difficulties
  - No treatment if patient asymptomatic
  - Trial of speech therapy for articulation problems. See Developmental Speech Disorders Rehabilitation AC or Dysarthria Rehabilitation AC for further information.

Evidence Summary

Background

Ankyloglossia (tongue-tie) is an anatomic variation in which the tissue that attaches the tongue to the bottom of the mouth (lingual frenulum) is abnormally short. Frenuloplasty is the surgical release of the frenulum with plastic repair, which is performed in both children and adults for a more complete release, whereas frenotomy (ie, frenulectomy or frenectomy) is the simple clipping of the frenulum without repair, which is usually performed in neonates and infants.(3) **(EG 2)**

Ankyloglossia may be a part of malformation syndromes but is commonly an isolated finding in normal infants. Some experts consider ankyloglossia to be only rarely symptomatic, whereas others consider it to lead to a host of problems, including infant feeding difficulties, speech disorders, and various mechanical and social issues related to the inability of the tongue to protrude sufficiently.(1)(4) **(EG 2)**

Criteria

For difficulty during breast-feeding, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A systematic review of 29 studies (including 5 randomized controlled trials) evaluated the effectiveness of surgical treatment (simple anterior frenectomy, laser frenulectomy, posterior frenulectomy, or Z-plasty repair) for infants with ankyloglossia and breast-feeding difficulties. There was low-level evidence that surgical intervention improved breast-feeding in the short term; however, longer-term outcomes were not reported, and there was insufficient evidence of the impact of surgical intervention on the duration of breast-feeding. The authors recommended additional studies of long-term outcomes, as well as comparative studies vs non-surgical treatments.(8) **(EG 1)** A prospective cohort study of 328 mother-infant pairs with frenulotomy for ankyloglossia and breast-feeding difficulty found improvement in breast-feeding, as measured by the LATCH score, 1 week postprocedure.(10) **(EG 2)** A study of 62 neonates with ankyloglossia and breast-feeding difficulty reported, at 2 weeks postprocedure, that there was a significant decrease in the frequency of breast-feeding and bottle supplementation as well as a significant increase in weight centile. Of those mothers who reported nipple problems (pain, cracking, bleeding), 100% were improved.

Latch difficulty was reported in 55% of cases and improved in 89%.(11) **(EG 2)** A specialty society statement indicates that frenotomy may improve breast-feeding in infants with ankyloglossia but states that the evidence is limited by variability in inclusion criteria, small trial size, and poorly defined outcomes.(12) **(EG 2)** Evidence-based review articles state that frenotomy is indicated and provides benefit when ankyloglossia creates breast-feeding difficulty. However, when ankyloglossia does not affect breast-feeding, no treatment is necessary.(6)(13) **(EG 2)**

For recurrent nipple pain, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A systematic review found inconsistent results of the effect of frenotomy on maternal nipple pain from breast-feeding infants with ankyloglossia; a randomized controlled trial of frenotomy on infants at 6 days of age showed a significant reduction in maternal pain, while studies with frenotomy performed on older infants did not. The authors concluded that further research is needed on the natural history of ankyloglossia, the effect of non-surgical treatments, and the appropriate age for frenotomy.(8) **(EG 1)**

Inconclusive or Non-Supportive Evidence

For speech articulation difficulties, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review of surgical interventions for speech difficulty in children with ankyloglossia found insufficient evidence to support frenuloplasty and frenectomy for the treatment of speech and articulation. A randomized controlled trial did find improvement in articulation without improved fluent speech scores; however, the remaining studies were of low quality with variable assessment of speech outcomes. The authors recommended additional research to determine the effect of frenotomy on children with speech problems due to ankyloglossia.(5) **(EG 1)**

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Footnotes

[A] A lactation consultant is a specialist trained in all aspects of breast-feeding. An International Board of Lactation Consultants certification is desirable. [A in Context Link 1, 2]

Codes

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Skilled members transitioned to Long term care (LTC)

Included: All lines of business

Formula:

1. Skilled authorization from 6/1/2018 pulled. Removed duplicate authorizations.
   345 total skilled authorizations.
2. LTC authorization from 9/1/2018 pulled. Removed any 7 day authorization assuming that these are bed holds. Removed duplicate authorizations.
   578 total LTC authorizations.
3. Combined skilled and LTC authorizations and identified duplicate members with skilled and LTC authorizations.
4. Verified that the LTC authorization was after the skilled authorization.

Summary:

- Total of 48 members that transitioned from skilled level of care to LTC level of care from 6/1/2018-12/13/2018.
- 46 out of 48 LTC authorizations are still current and active. 2 had an end date in August and November.

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 Contractors, 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 SCFHP is responsible for coordination of programs including the UM Program. The Utilization Management 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 Director and Utilization Manager are 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 Supervisor

Responsible for the daily operational management of the Utilization Management Department activities, such as: authorization processing, letter creation, provider outreach and education, productivity and quality monitoring oversight, training and development, and the daily supervision of non-clinical Utilization Care Coordination 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 Registered 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) Utilization Management Review Nurse (LVN)

Under the guidance and direction of the UM department RN Manager or Health Services Director, Licensed Vocational nurses are responsible for performing prospective and retrospective pre-service clinical review for inpatient and outpatient authorization requests in compliance with all applicable state and federal regulatory requirements, SCFHP policies and procedures, and applicable business requirements. Following regulatory or evidence-based guidelines, assesses for medical necessity of services and/or benefit coverage which result in approved determination for services or the need to collaborate with Medical Directors for potential denial considerations.

h) Nurse Case Managers

Case management services at the SCFHP are licensed registered nurses (RN) or licensed clinical social workers (LCSW) 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.

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
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:

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.

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.

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. Comorbidities
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. .

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 UM Manager monitors the consistency of the UM/BH/MLTSS/Pharmacy staff iin handling pre service approval, denial and inpatient concurrent review decisions. The Inter-Rater Reliability (IRR) testing process evaluates the consistent application amongst the Health Services teams (UM, BH, MLTSS, pharmacy staff), including all staff who apply medical necessity criteria, including medical directors, registered and licensed vocational nursing staff, pharmacists, pharmacy technicians, non-clinical staff. Please refer to IRR Policy HS.09.01.

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.

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.

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

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.

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.

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.

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) SCFHP routinely receives clinical reports from Santa Clara County Behavioral Health Services Department, which are reviewed by the Manager of Behavioral Health Department or other designee.
d) SCFHP participates in quarterly operational meetings with the CBHSD to review and coordinate administrative, clinical and operational activities.

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

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

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

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.

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

UM Policy changes		
Number	Title	Changes
HS.01	Prior Authorization	Title change from Prior -Authorization /Org determinations Updated section H&I: H. The Plan maintains a ~~protocol~~ procedure for~~regarding~~ Continuity of Care for both medical and behavioral health services. I. Out of Area and Out of Network requests are processed in accordance to the Member's Evidence of coverage, the Plan's Continuity of Care ~~protocol~~ procedure for medical and behavioral health and reviewed based on medical necessity.
HS.02	Medical Necessity Criteria	Update section B: 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 services and procedures requested.
HS.03	Appropriate Use of Professionals	Update section B and D: 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 Care Coordinator~~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. D. Non-licensed and licensed staff receive training and daily supervision by UM Supervisor, UM Manager, Medical Management Director and Medical Directors.~~.~~
HS.04	Denial of Services Notification	Update section C:

		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 within the DHCS threshold language requirement 9. Advises that notifications are available in ~~threshold~~ other languages upon request
HS.05	Evaluation of New Technology	No changes from 2018
HS.06	Emergency Services	No changes from 2018
HS.07	Long Term Care Utilization Review	Re numbered from HS.14 to HS.07 Update sections D, E, F and I:

Santa Clara Family Health Plan™

		D. Non contracted providers and Out of area providers will follow Out of Network/Out of Area Procedure for Utilization review. ~~For a non-contracted facility requesting authorization for services, SCFHP Health Services Department initiates the SCFHP Letter of Agreement (LOA) contracting process to negotiate case rates with non-contracting providers who render services to SCFHP members. In accordance with the Medi-Cal Evidence of Coverage/or CMC Member Handbook, SCFHP is licensed to serve members who live in Santa Clara County. The requested long-term nursing care is outside of Santa Clara County and therefore excluded from coverage.~~[JC1] E. SCFHP notifies LTC providers of required supporting documentation for Utilization review. ~~Documentation supporting a completed LTC PAR form shall include: Care plan, face sheet and physician orders, Medicare or other insurance denial as appropriate, and Preadmission Screening and Resident Review (PASRR) Screening Level 1 Document forms.~~[JC2]- When PAR submissions do not include required documentation, SCFHP will follow up with the nursing facility with 3 outreach attempts to request the documents and if they are not received, the PAR will be reviewed and possibly denied by a medical professional for insufficient information. F. On-site level of care review by an ~~RN~~ Licensed Nurse for an LTC PAR may be performed at the discretion of SCFHP. This review shall include an assessment of the Member and review of the medical orders, care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data to assist SCFHP staff in making an appropriate determination on the authorization request. On-site review may be done when indicated for patterns of high service utilization, frequent acute hospitalization, and/or large number of member complaints or concerns. I. Bed Hold ~~I.~~ a) SCFHP shall include as a separate benefit any leave of absence or Bed Hold that a nursing facility provides in accordance with Medi-Cal requirements b) ~~J.~~ ~~A separate authorization request is required for~~ Bed Holds (BH) and should be submitted by the SNF at the time of transfer • c) The member's attending physician must write a physician order for a discharge or transfer at the time a member requires a discharge or transfer from an LTC facility to a General Acute Care Hospital and include an order for Bed Hold. d) ~~K.~~ ~~A~~ Bed Hold (BH) ~~for a member transferred to a General Acute Care Hospital~~ is limited to seven (7) calendar days per ~~hospitalization.~~ discharge • ~~An LTC facility shall hold a bed vacant when requested by a member or a member's authorized representative, unless notified in writing by the attending physician that the member requires more than seven (7) days of general acute care hospital care.~~

HS.08	Second Opinion	No changes from 2018
HS.09	Inter-Rater Reliability	Update section B, III and IV: ~~II.~~ B. 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~~ by Medical Management Leadership 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~~UMC. **IV. 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
HS.10	Financial Incentive	No changes from 2018
HS.11	Informed Consent	No changes from 2018
HS.12	Preventive Health Guidelines	No changes from 2018

Santa Clara Family Health Plan

HS.13	Transportation Services	New Policy

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Prior Authorization**	**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.

POLICY

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 procedure for Continuity of Care for both medical and behavioral health services.

I. Out of Area and Out of Network requests are processed in accordance to the Member's Evidence of coverage, the Plan's Continuity of Care procedure for medical and behavioral health and reviewed based on medical necessity.

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.

K. 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.

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

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

N. 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)

O. 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 17, 2018	Title January 17, 2018
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**	
V1	**Reviewed**	**Utilization Management**	**Approved/1/17/18**	

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 services and procedures requested.
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	Jeff Robertson, MD
Signature	Signature
Sandra Carlson	Jeff Robertson, MD
Name	Name
Health Services Director	Chief Medical Officer
Title	Title
01/17/2018	01/17/2018
Date	Date

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v1	**Original**	**Utilization Management**	**Approve 4/20/2016**	
	Original	**Utilization Management**	**Approve 01/18/2017**	
	Reviewed	**Utilization Management**	**Approve 01/17/2018**	

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 Care Coordinator 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 by UM Supervisor, UM Manager, Medical Management Director and Medical Directors.
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 01/17/2018	Title 01/17/2018
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**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	

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 within the DHCS threshold language requirement
9. Advises that notifications are available in other 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.

Department of Health Care Services. ALL PLAN LETTER 17-011 STANDARDS FOR DETERMINING THRESHOLD LANGUAGES AND REQUIREMENTS FOR SECTION 1557 OF THE AFFORDABLE CARE ACT. Retrieved 12/18/2018*https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-011.pdf*

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 **01/17/2018**	Title 01/17/2018
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**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	

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 01/17/2018	Title 01/17/2018
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**	
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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 01/17/2018	Title 01/17/2018
Date	Date

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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
	
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Name Director of Health Services	Name Chief Medical Officer
Title 01/17/2018	Title 01/17/2018
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**	
V1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Inter-Rater Reliability**	**Policy No.:**	HS.09
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) Inter-Rater 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 by Medical Management Leadership 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 UMC.

IV. 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

V. Reference

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

VII. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature Sandra Carlson Name Health Services Director Title 01/17/2018 Date	Jeff Robertson MD Signature Jeff Robertson, MD Name Chief Medical Officer Title 01/17/2018 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	
1	Reviewed	Utilization Management	Approve 01/17/2018	

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 01/17/2018	Title 01/17/2018
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**	
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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

POLICY

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 01/17/2018	Title 01/17/2018
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**	
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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 01/17/2018	Title 01/17/2018
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**	
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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. 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.

Nurse Advice Line summary reports are monitored and reported to UMC on a quarterly basis.

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 01/18/2018	Title 01/18/2018
Date	Date

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V1.0	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Transportation Services**	**Policy No.:**	HS.14
Replaces Policy Title (if applicable):	Non-Emergency Medical and Non-Medical Transportation Services	**Replaces Policy No. (if applicable):**	HS.14
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 (SCFHP) coverage for emergency, non-emergency medical (NEMT) and non-medical transportation services (NMT).

II. Policy

Emergency Medical Transportation

A. Emergency medical transportation does not require prior authorization. Detailed information regarding emergency services is available in Policy and Procedures HS.06 Emergency Services - Medical and HS.06.01 Emergency and Post-Stabilization Services

Non-Emergency Medical Transportation (NEMT) Services

A. NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist or mental health or substance use disorder provider. NEMT services are subject to prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of case, to a skilled nursing facility or an intermediate care facility. SCFHP will make our best effort to refer for and coordinate NEMT for carved out services.
B. Medical professional's decisions regarding NEMT will be unhindered by fiscal and administrative management. SCFHP will authorize, at a minimum, the lowest cost type of NEMT transportation that is adequate for the member's medical needs. There are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has a prior authorization.
C. SCFHP will provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. The plan will provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The plan will ensure door-to-door assistance for all members receiving NEMT services.

POLICY

D. SCFHP will provide transportation for a parent or a guardian when the member is a minor. With written consent of a parent or guardian, SCFHP will arrange NEMT for a minor who is unaccompanied by a parent or guardian. SCHFP will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service.
E. SCFHP will provide the following four available modalities of NEMT when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:
    a. Ambulance services
    b. Litter van services
    c. Wheelchair van services
    d. Air
F. SCFHP will use a DHCS approved physician certification statement (PCS) form to determine the appropriate level of service. Once the member's treating physician prescribes the form of transportation, SCFHP will not modify the authorization. PCS form must be completed before NEMT can be prescribed and provided.
G. SCFHP will capture and submit data from the PCS form to DHCS.

Non-Medical Transportation (NMT) Services

A. SCFHP will provide NMT for members to obtain medically necessary services like primary care and specialty appointments, mental health, substance use disorder, dental and other services covered by SCFHP. In addition, SCFHP will also provide NMT for any other benefits delivered through the Medi-Cal FFS delivery system.
B. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter cans, or wheelchair vans.
C. SCFHP will provide round trip-transportation for a member to obtain covered and carved out Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance.
D. The NMT approved must be the least costly method of transportation that meets the member's needs.
E. As a Member Services Guide, SCFHP will include information in the Evidence of Coverage on the procedures for obtaining NMT services, a description of NMT services and the conditions under which NMT is available.
F. NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation.
G. SCFHP will provide transportation for a parent or a guardian when the member is a minor. With written consent of a parent or guardian, SCFHP will arrange NMT for a minor who is unaccompanied by a parent or guardian. SCHFP will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service.
H. SCFHP will provide mileage reimbursement consistent with the IRS rate for medical purposes when conveyance is in a private vehicle arranged by the member. The member must attest in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. In order to receive gas mileage reimbursement for use of a private

vehicle, the driver must have a valid driver's license, valid vehicle registration, and valid vehicle insurance.

I. NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

SCFHP will meet DHCS contractually required timely access standards for NEMT and NMT.

III. Responsibilities

Health Services will review prior authorization for NEMT.
Customer Services will coordinate NMT and NEMT.
Provider Network Management will educate the provider network on NEMT and NMT benefits and requirements.
Health Services, Claims, Grievances & Appeals, and Customer Service will gather data for submission.

IV. References

APL 17-010 Non-Emergency Medical and Non-Medical Transportation Services

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
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			
V2	Revised			

Santa Clara
Family Health Plan

POLICY

Policy Title:	**Long Term Care Utilization Review**	**Policy No.:**	HS.15
Replaces Policy Title (if applicable):	**Authorization and Review Process – Long Term Care (LTC)**	**Replaces Policy No. (if applicable):**	No applicable
Issuing Department:	Health Services	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	X Medi-Cal	□ Healthy Kids	X CMC

I. Purpose

To define and outline the requirements for reviewing and processing Long Term Care (LTC) authorizations and reauthorizations for a member's admission to, continued stay in, or discharge from a Skilled Nursing Facility (SNF)

II. Policy

A. SCFHP Health Services (HS) shall authorize utilization of Medi-Cal LTC services for its members when medically necessary and determine level of care and length of stay based on the member's current assessment and consistent with Medi-Cal criteria.

B. Requests for admission to, continued stay in, or discharge from any LTC facility shall be processed in accordance with the California Department of Health Services (DHCS) standard clinical criteria for LTC level of service. LTC level of care Prior Authorization Request (PAR) processing procedure will be in compliance with applicable regulatory requirements.

C. Decisions to deny or to authorize an duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease or Managed Long Term Services and Supports (MLTSS) needs.

D. Non contracted providers and Out of area providers will follow Out of Network/Out of Area Procedure for Utilization review.

E. SCFHP notifies LTC providers of required supporting documentation for Utilization review. When PAR submissions do not include required documentation, SCFHP will follow up with the nursing facility with 3 outreach attempts to request the documents and if they are not received, the PAR will be reviewed and possibly denied by a medical professional for insufficient information.

F. On-site level of care review by an Licensed Nurse for an LTC PAR may be performed at the discretion of SCFHP. This review shall include an assessment of the Member and review of the medical orders, care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data to assist SCFHP staff in making an appropriate determination on the authorization request. On-site review may be done when indicated for patterns of high service utilization, frequent acute hospitalization, and/or large number of member complaints or concerns.

G. Reauthorization of an LTC PAR shall be submitted by the nursing facility to SCFHP prior to the expiration of the active LTC PAR. The requests shall include a completed LTC PAR signed by a physician, the most recent Quarterly Assessment MDS, and sufficient documentation to justify the level of care and continued stay. Reauthorizations for LTC may be approved for up to one year.

H. SCFHP may arrange and coordinate with the nursing facility for modification of care or discharge of a member from a nursing facility if it determines that one or more of the following circumstances are present:
- The SNF is no longer capable of meeting the member's health care needs;
- The member's health has improved sufficiently so that he or she no longer needs SNF services; or
- The member poses a risk to the health or safety of individuals in the nursing facility.
- The SNF does not meet SCFHP network standards because of documented quality of care concerns.

I. Bed Hold
a) SCFHP shall include as a separate benefit any leave of absence or Bed Hold that a nursing facility provides in accordance with Medi-Cal requirements b)Bed Holds (BH) and should be submitted by the SNF at the time of transfer
c) The member's attending physician must write a physician order for a discharge or transfer at the time a member requires a discharge or transfer from an LTC facility to a General Acute Care Hospital and include an order for Bed Hold.
d) Bed Hold (BH) is limited to seven (7) calendar days per discharge

J. SCFHP shall be responsible for the timely provision of a member's medical needs, supports and services through the LTC post-discharge and transition to community. The discharge planning may include but is not limited to:
- Documentation of pre-admission, or baseline status including: living arrangements, functional status, durable medical equipment (DME) and other services received; understanding of medical condition or functional status by the member or representative, physical and mental health status, financial resources and social supports.
- Initial set-up of services needed after discharge including medical care, medication, DME, identification and integration of long term services and supports, type of placement preferred and agreed to, hospital recommendations and pre-discharge counseling recommended.
- Initial coordination of care, as appropriate with the member's caregiver, other agencies and knowledgeable personnel, as well as providing care coordination contact information for the facility.
- Provision of information for making follow up appointments

References

SCFHP Utilization Management Program Description

1. Duals Plan Letter (DPL) 14-002 Requirements for Nursing Facility Services
2. Duals Plan Letter (DPL) 14-004 Continuity of Care
3. Duals Plan (DPL) 16-003; Discharge Planning for Cal MediConnect
4. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
5. Title 22, California Code of Regulations (CCR) §§ 51120, 51121, 51124, 5125, 51118, and 51212
6. Welfare &Institutions Code §§ 14087.55, 14087.6, 14087.9 and 14103.06

III. Approval/Revision History

First Level Approval	Second Level Approval
Signature Lori Andersen, Director, Managed Long Term Services and Supports Title	Signature Jeff Robertson, MD, Chief Medical Officer
Name/Title	Name/Title
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				

Santa Clara Family Health Plan Membership Report

	2018-10	2018-11	2018-12	2019-01
HK	**3,217**	**3,460**	**3,345**	**3,252**
Palo Alto Medical Foundation	97	94	89	88
Physicians Medical Group	1,144	1,227	1,200	1,131
Premier Care	234	248	233	243
Independent Physicians	338	386	382	382
VHP Network	1,404	1,505	1,441	1,408
MC	**244,493**	**243,399**	**242,695**	**239,998**
Kaiser Permanente	25,801	25,682	25,468	25,152
Medicare Primary	13,931	14,132	14,270	14,262
Palo Alto Medical Foundation	7,133	7,082	7,055	6,999
Physicians Medical Group	44,553	44,100	43,866	43,311
Premier Care	15,176	15,139	15,110	14,946
Independent Physicians	15,776	15,760	15,813	15,655
VHP Network	122,123	121,504	121,113	119,673
CMC	**7,601**	**7,625**	**7,695**	**7,750**
Santa Clara Family Health Plan	7,601	7,625	7,695	7,750
Grand Total	**255,311**	**254,484**	**253,735**	**251,000**

Santa Clara Family Health Plan

UTILIZATION MANAGEMENT DASHBOARD
(Includes: UM, MLTSS: BH)

Cal MediConnect:

	2018					
	Oct	Nov	Dec	Q4 2018	FY 18-19	YTD
Pre-Service Organization Determinations - HS						
Standard Part C						
# of Prior Authorization Requests Received	489	482	419	**1,390**	**2,793**	**5,796**
# of Prior Auth Requests Completed within 14 days	485	476	415	**1,376**	**2,772**	**5,628**
% of Timely Decisions made within 14 days	99.2%	98.8%	99.0%	**99.0%**	**99.2%**	**97.1%**
# Approved	466	456	396	**1,318**	**2,647**	**5,524**
# Denied	23	26	23	**72**	**148**	**274**
% Approved	95.3%	94.6%	94.5%	**94.8%**	**94.8%**	**95.3%**
# of Prior Authorization Notification Sent	489	482	419	**1,390**	**2,793**	**3,226**
# of Prior Authorization Notification Sent Within 14 Days	484	476	412	**1,372**	**2,758**	**3,170**
% Timely Notification of HS decision	99.0%	98.8%	98.3%	**98.7%**	**98.7%**	**98.3%**
Expedited Part C						
# of Prior Authorization Requests Received	221	218	225	**664**	**1,289**	**2,585**
# of Prior Auth Requests Completed within 72 Hours	218	215	225	**658**	**1,275**	**2,493**
% of Timely Decisions made within 72 Hours	98.6%	98.6%	100.0%	**99.1%**	**98.9%**	**96.4%**
# of Requests with Extensions	unavailable	unavailable	unavailable	**unavailable**	**unavailable**	**unavailable**
# Approved	205	212	211	**628**	**1,209**	**2,418**
# Denied	16	6	14	**36**	**82**	**169**
% Approved	92.8%	97.2%	93.8%	**94.6%**	**93.8%**	**93.5%**
# of Prior Authorization Notification Sent	221	218	225	**664**	**1,286**	**1,499**
# of Prior Authorization Notification Sent Within 72 hours	215	212	222	**649**	**1,251**	**1,451**
% timely notification of HS decision	97.3%	97.2%	98.7%	**97.7%**	**97.3%**	**96.8%**
Urgent Concurrent Organization Determinations						
# of Urgent Concurrent Requests Received	11	17	10	**38**	**78**	**133**
# of Urgent Concurrent Requests Completed within 24 Hours	11	16	9	**36**	**63**	**103**
% of Timely Decisions made within 24 Hours	100.0%	94.1%	90.0%	**94.7%**	**80.8%**	**77.4%**
# Approved	11	17	10	**38**	**77**	**132**
# Denied	0	0	0	**-**	**1**	**1**
% Approved	100.0%	100.0%	100.0%	**100.0%**	**98.7%**	**99.2%**
# of Prior Authorization Notification Sent	11	17	10	**38**	**78**	**90**
# of Prior Authorization Notification Sent Within 24 hours	11	16	9	**36**	**64**	**71**
% timely notification of HS decision	100.0%	94.1%	90.0%	**94.7%**	**82.1%**	**78.9%**
Post Service Organization Determinations						
# of Requests Received	51	42	39	**132**	**226**	**453**
# of Post Service Requests Completed within 30 Days	51	42	39	**132**	**223**	**438**
% of Timely Decisions made within 30 days	100.0%	100.0%	100.0%	**100.0%**	**98.7%**	**96.7%**
# of Requests with Extensions	unavailable	unavailable	unavailable	**unavailable**	**unavailable**	**unavailable**
# Approved	49	41	39	**129**	**222**	**446**
# Denied	2	1	0	**3**	**4**	**7**
% Approved	96.1%	97.6%	100.0%	**97.7%**	**98.2%**	**98.5%**
# of Prior Authorization Notification Sent	51	42	39	**132**	**223**	**255**
# of Prior Authorization Notification Sent Within 30 Days	51	40	37	**128**	**216**	**247**
% timely notification of HS decision	100.0%	95.2%	94.9%	**97.0%**	**96.9%**	**96.9%**

Medi-Cal:

	2018					
	Oct	Nov	Dec	Q4 201	FY 18-1	YTD
UTILIZATION MANAGEMENT						
Medical Authorizations – HS Combined						
Routine Authorizations						
# of Routine Prior Authorization Requests Received	1,143	985	871	**2,999**	**6,040**	**12,993**
# of Routine Prior Authorization Requests Completed within 5 Business Days	1,116	953	851	**2,920**	**5,922**	**12,032**
% of Timely Decisions made within 5 Business Days of request	97.6%	96.8%	97.7%	**97.4%**	**98.0%**	**92.6%**
# of Prior Authorization Notification Sent	1,143	985	871	**2,999**	**6,040**	**7,044**
# of Prior Authorization Notification Sent Within 5 Business Days	1,117	973	846	**2,936**	**5,912**	**6,873**
% timely notification of HS decision	97.7%	98.8%	97.1%	**97.9%**	**97.9%**	**97.6%**
Expedited Authorizations						
# of Expedited Prior Authorization Requests Received	219	148	155	**522**	**1,034**	**2,205**
# of Expedited Prior Authorization Requests Completed within 72 Hours	217	148	153	**518**	**1,027**	**2,141**
% of Timely Decisions made within 72 Hours of request	99.1%	100.0%	98.7%	**99.2%**	**99.3%**	**97.1%**
# of Prior Authorization Notification Sent	219	148	155	**522**	**1,034**	**1,266**
# of Prior Authorization Notification Sent Within 72 hours	216	147	152	**515**	**1,019**	**1,248**
% timely notification of HS decision	98.6%	99.3%	98.1%	**98.7%**	**98.5%**	**98.6%**
Urgent Concurrent Review						
# of Urgent Concurrent Requests Received	11	11	7	**29**	**62**	**111**
# of Urgent Concurrent Requests Completed within 24 Hours of request	11	8	7	**26**	**58**	**94**
% of Timely Decisions made within 24 Hours of request	100.0%	72.7%	100.0%	**89.7%**	**93.5%**	**84.7%**
# of Prior Authorization Notification Sent	11	11	7	**29**	**62**	**67**
# of Prior Authorization Notification Sent Within 24 hours	11	11	7	**29**	**61**	**65**
% timely notification of HS decision	100.0%	100.0%	100.0%	**100.0%**	**98.4%**	**97.0%**
Retrospective Review						
# of Retrospective Requests Received	349	333	217	**899**	**1,450**	**2,118**
# of Retrospective Requests completed within 30 Calendar Days of request	346	331	217	**894**	**1,441**	**2,066**
% of Retrospective Reviews completed within 30 Calendar Days of request	99.1%	99.4%	100.0%	**99.4%**	**99.4%**	**97.5%**
# of Prior Authorization Notification Sent	349	333	217	**899**	**1,450**	**1,606**
# of Prior Authorization Notification Sent Within 30 Calendar days	342	327	215	**884**	**1,425**	**1,569**
% timely notification of HS decision	98.0%	98.2%	99.1%	**98.3%**	**98.3%**	**97.7%**
Denied Authorizations (Routine, Expedited, CCR, Retro)						
Total Requests Approved	1722	1477	1180	**4379**	**8,375**	**16,733**
Total Requests Denied	89	52	70	**211**	**409**	**892**
Total Requests Pended/Extended	0	0	0	**0**	-	-
Total Requests Cancelled	0	0	0	**0**	-	-
% of Total Requests Denied	5.2%	3.5%	5.6%	**4.7%**	**4.8%**	**5.1%**

Santa Clara Family Health Plan™

Utilization Management Committee (UMC)

January 2019

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 10/1/2017 – 9/30/2018

Source: HEDIS Inpatient Utilization (IPU) data for measurement year ending 9/30/2018

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2017 Q4	2,326	3.65	8,361	3.59
2018 Q1	2425	3.88	8,688	3.58
2018 Q2	2,346	3.61	7,723	3.48
2018 Q3	2,333	3.86	8,326	3.57
Total	9,302	3.75	33,098	3.56

Inpatient Utilization: Medi-Cal – SPD 10/1/2017 – 9/30/2018

Source: HEDIS Inpatient Utilization (IPU) data for measurement year ending 9/30/2018

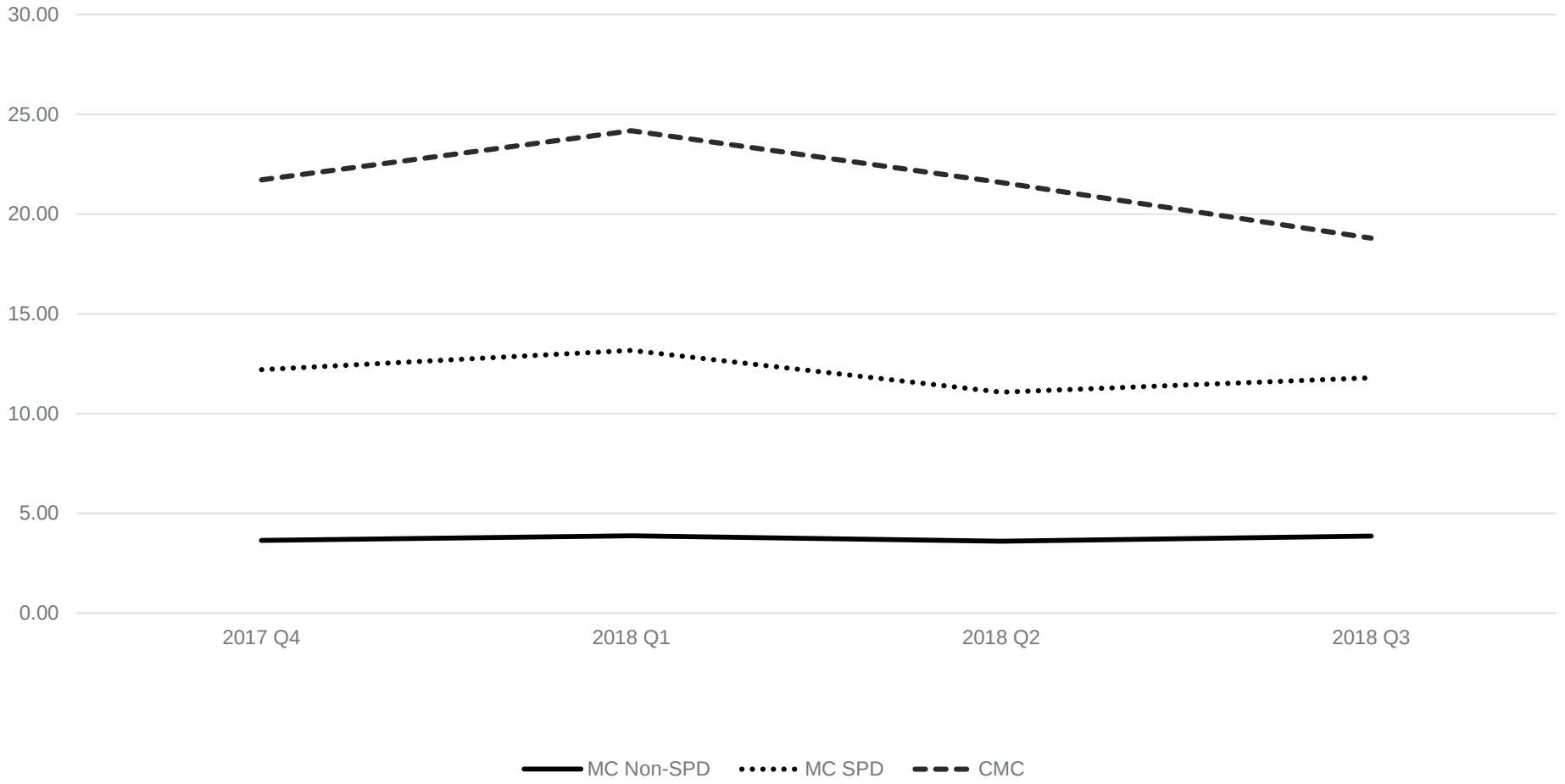
Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2017 Q4	809	12.21	4,040	4.99
2018 Q1	875	13.17	4,126	4.72
2018 Q2	736	11.08	3,479	4.73
2018 Q3	777	11.80	3,440	4.43
Total	3,197	12.06	15,085	4.72

Inpatient Utilization: Cal MediConnect (CMC)
10/1/2017 – 9/30/2018

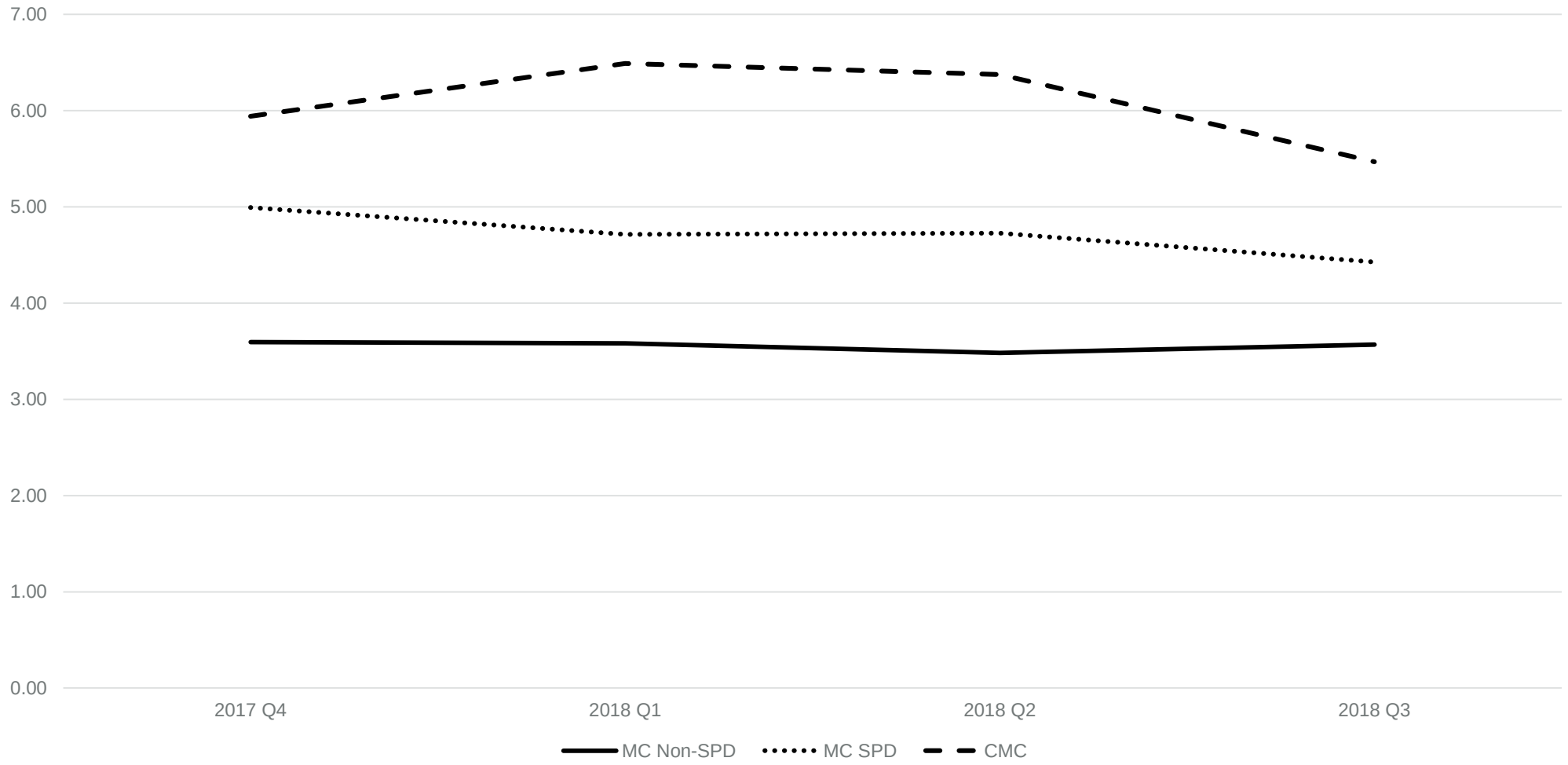
Source: CMC Enrollment & QNXT Claims Data

Quarter	Discharges	Discharges / 1,000 Members per Year	Days	Average Length of Stay
2017 Q4	487	260.7	2,894	5.94
2018 Q1	547	290.2	3,550	6.49
2018 Q2	492	259.1	3,137	6.38
2018 Q3	434	225.5	2,374	5.47
Total	1,960	258.7	11,955	6.10

SCFHP Medi-Cal & Cal MediConnect
Acute Inpatient Discharges per 1,000 Member Months (MM)
10/1/2017 – 9/30/2018



SCFHP Medi-Cal & Cal MediConnect
Acute Inpatient Average Length of Stay (ALOS)
10/1/2017 – 9/30/2018



Medi-Cal Inpatient Utilization NCQA Medicaid Benchmark Comparisons 10/1/2017 – 9/30/2018

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	3.75	12.06	4.55
NCQA Medicaid Percentile Rank[1]	<10th	>90th	<10th
ALOS	3.56	4.72	3.85
NCQA Medicaid Percentile Rank[2]	<25th	>75th	<50th

[1] NCQA Medicaid 50th percentile = 6.54
[2] NCQA Medicaid 50th percentile = 4.18

Medi-Cal SPD & CMC Inpatient Utilization
MCG & NCQA Medicare Benchmark Comparisons
10/1/2017 – 9/30/2018

	Discharges / 1,000 Members per Year	Days / 1,000 Members per Year	ALOS
SCFHP Population			
Medi-Cal SPD	144.7	683.0	4.72
CMC	258.7	1577.84	6.10
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	214.6	1,208.9	5.41

Inpatient Readmissions: Medi-Cal – Non-SPD

Source: HEDIS All Cause Readmissions (ACR) data for 10/1/2017 – 9/30/2018 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2017 Q4	1166	182	15.61%
2018 Q1	1153	177	15.35%
2018 Q2	1141	200	17.53%
2018 Q3	837	133	15.89%
Total	4,258	692	16.10%

[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: HEDIS All Cause Readmissions (ACR) data for 10/1/2017 – 9/30/2018 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2]
2017 Q4	795	175	22.01%
2018 Q1	865	196	22.66%
2018 Q2	750	162	21.60%
2018 Q3	572	116	20.28%
Total	2,982	649	21.76%

[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 10/1/2017 – 9/30/2018 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2017 Q4	350	63	18%
2018 Q1	372	59	15.86%
2018 Q2	364	55	15.11%
2018 Q3	204	21	10.29%
Total	1290	198	15.35%

[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 10/1/2017 – 9/30/2018 measurement period

Rate Description	Ages 18 – 64 (PCR-A)	Ages 65+ (PCR-B)
Count of Index Hospital Stays	316	974
Count of 30-Day Readmissions	64	134
Actual Readmission Rate	20.25%	13.76%
NCQA Medicare 50th Percentile	16.34%	12.68%
SCFHP Percentile Ranking	>90th	>50th

[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 10/1/2017 – 9/30/2018 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	193	0.31	0.63	↓
Male & Female, Age 10-19	89	0.13	0.29	↓
Hysterectomy, abdominal				
Female, Age 15-44	20	0.03	0.10	↓
Female, Age 45-64	49	0.16	0.24	↓
Hysterectomy, vaginal				
Female, Age 15-44	28	0.05	0.10	↓
Female, Age 45-64	30	0.1	0.17	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 10/1/2017 – 9/30/2018 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	7	0.02	0.03	↓
Female, Age 15-44	3	0.01	0.01	↔
Female, Age 45-64	5	0.02	0.03	↓
Cholecystectomy, closed (laparoscopic)				
Male, Age 30-64	64	0.16	0.26	↓
Female, Age 15-44	253	0.43	0.61	↓
Female, Age 45-64	80	0.27	0.58	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 10/1/2017 – 9/30/2018 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	18	0.06	0.19	↓
Female, Age 20-44	12	0.03	0.14	↓
Male, Age 45-64	36	0.15	0.52	↓
Female, Age 45-64	42	0.14	0.51	↓
Mastectomy				
Female, Age 15-44	15	0.03	0.02	↑
Female, Age 45-64	27	0.09	0.12	↓
Lumpectomy				
Female, Age 15-44	46	0.08	0.11	↓
Female, Age 45-64	88	0.3	0.34	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 10/1/2017 – 9/30/2018 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	1	0.01	0.00	↑
Male, Age 20-44	2	0.01	0.01	↔
Female, Age 20-44	44	0.1	0.05	↑
Male, Age 45-64	5	0.02	0.01	↑
Female, Age 45-64	22	0.07	0.06	↑

ADHD Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 10/1/2017 – 9/30/2018 measurement period

Measure	Rate	NCQA Medicaid 50th Percentile	SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	29.30%	44.80%	>10th
Continuation & Maintenance Phase	22.95%	55.90%	<10th
Antidepressant Medication Management			
Acute Phase Treatment	60.67%	57.90%	>75th
Continuation Phase Treatment	40.07%	36.21%	>50th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	50%	77.94%	<10th

Santa Clara Family Health Plan™

Questions?

Santa Clara Family Health Plan™

UTILIZATION MANAGEMENT DASHBOARD FOR MLTSS

Cal MediConnect:

	2018					
	Oct	Nov	Dec	Q4 2018	FY 18-19	YTD
Pre-Service Organization Determinations - MLTSS						
Standard Part C						
# of Prior Authorization Requests Received	26	26	19	**71**	**173**	**490**
# of Prior Auth Requests Completed within 14 days	26	26	19	**71**	**173**	**469**
% of Timely Decisions made within 14 days	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**95.7%**
# Approved	26	26	19	**71**	**173**	**488**
# Denied	0	0	0	-	-	**2**
% Approved	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**99.6%**
# of Prior Authorization Notification Sent	26	26	19	**71**	**173**	**214**
# of Prior Authorization Notification Sent Within 14 Days	26	26	19	**71**	**173**	**210**
% timely notification of MLTSS decision	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**98.1%**
Expedited Part C						
# of Prior Authorization Requests Received	0	1	0	**1**	**1**	**1**
# of Prior Auth Requests Completed within 72 Hours	0	1	0	**1**	**1**	**1**
% of Timely Decisions made within 72 Hours	n/a	100.0%	n/a	**100.0%**	**100.0%**	**100.0%**
# of Requests with Extensions	unavailable	unavailable	unavailable	**unavailable**	**unavailable**	**unavailable**
# Approved	0	1	0	**1**	**1**	**1**
# Denied	0	0	0	-	-	-
% Approved	n/a	100.0%	n/a	**100.0%**	**100.0%**	**100.0%**
# of Prior Authorization Notification Sent	0	1	0	**1**	**1**	**1**
# of Prior Authorization Notification Sent Within 72 hours	0	1	0	**1**	**1**	**1**
% timely notification of MLTSS decision	n/a	100.0%	n/a	**100.0%**	**100.0%**	**100.0%**
Urgent Concurrent Organization Determinations						
# of Urgent Concurrent Requests Received	0	0	0	-	-	-
# of Urgent Concurrent Requests Completed within 24 Hours	0	0	0	-	-	-
% of Timely Decisions made within 24 Hours	n/a	n/a	n/a	**n/a**	**n/a**	**n/a**
# Approved	0	0	0	-	-	-
# Denied	0	0	0	-	-	-
% Approved	n/a	n/a	n/a	**n/a**	**n/a**	**n/a**
# of Prior Authorization Notification Sent	0	0	0	-	-	-
# of Prior Authorization Notification Sent Within 24 hours	0	0	0	-	-	-
% timely notification of MLTSS decision	n/a	n/a	n/a	**n/a**	**n/a**	**n/a**
Post Service Organization Determinations						
# of Requests Received	17	19	14	**50**	**90**	**129**
# of Post Service Requests Completed within 30 Days	17	19	14	**50**	**90**	**129**
% of Timely Decisions made within 30 days	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**100.0%**
# of Requests with Extensions	unavailable	unavailable	unavailable	**unavailable**	**unavailable**	**unavailable**
# Approved	17	19	14	**50**	**89**	**128**
# Denied	0	0	0	-	**1**	**1**
% Approved	100.0%	100.0%	100.0%	**100.0%**	**98.9%**	**99.2%**
# of Prior Authorization Notification Sent	17	19	14	**50**	**90**	**94**
# of Prior Authorization Notification Sent Within 30 Days	17	19	14	**50**	**90**	**94**
% timely notification of MLTSS decision	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**100.0%**

Medi-Cal:

	2018					
	Oct	Nov	Dec	Q4 2018	FY 18-19	YTD
Medical Authorizations - MLTSS						
Routine Authorizations						
# of Routine Prior Authorization Requests Received	205	172	130	**507**	**1,185**	**2,903**
# of Routine Prior Authorization Requests Completed within 5 Business Days	201	172	129	**502**	**1,169**	**2,429**
% of Timely Decisions made within 5 Business Days of request	98.0%	100.0%	99.2%	**99.0%**	**98.6%**	**83.7%**
# of Prior Authorization Notification Sent	205	172	130	**507**	**1,185**	**1,471**
# of Prior Authorization Notification Sent Within 5 Business Days	203	171	128	**502**	**1,169**	**1,448**
% timely notification of MLTSS decision	99.0%	99.4%	98.5%	**99.0%**	**98.6%**	**98.4%**
Expedited Authorizations						
# of Expedited Prior Authorization Requests Received	0	0	0	-	-	**1**
# of Expedited Prior Authorization Requests Completed within 72 Hours	0	0	0	-	-	-
% of Timely Decisions made within 72 Hours of request	n/a	n/a	n/a	**#DIV/0!**	**#DIV/0!**	**0%**
# of Prior Authorization Notification Sent	0	0	0		**unavailable**	**unavailable**
# of Prior Authorization Notification Sent Within 72 hours	0	0	0		**unavailable**	**unavailable**
% timely notification of MLTSS decision	n/a	n/a	n/a	**n/a**	**unavailable**	**unavailable**
Urgent Concurrent Review						
# of Urgent Concurrent Requests Received	0	0	0	-	-	-
# of Urgent Concurrent Requests Completed within 24 Hours of request	0	0	0	-	-	-
% of Timely Decisions made within 24 Hours of request	n/a	n/a	n/a	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
# of Prior Authorization Notification Sent	0	0	0		**unavailable**	**unavailable**
# of Prior Authorization Notification Sent Within 24 hours	0	0	0		**unavailable**	**unavailable**
% timely notification of MLTSS decision	n/a	n/a	n/a	**n/a**	**unavailable**	**unavailable**
Restrospective Review						
# of Retrospective Requests Received	200	163	108	**471**	**828**	**1,078**
# of Retrospective Requests completed within 30 Calendar Days of request	200	163	108	**471**	**828**	**1,071**
% of Retrospective Reviews completed within 30 Calendar Days of request	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**99.4%**
# of Prior Authorization Notification Sent	200	163	108	**471**	**828**	**882**
# of Prior Authorization Notification Sent Within 30 Calendar days	199	161	108	**468**	**820**	**870**
% timely notification of MLTSS decision	99.5%	98.8%	100.0%	**99.4%**	**99.0%**	**98.6%**
Denied Authorizations (Routine, Expedited, CCR, Retro)						
Total Requests Approved	405	335	268	**1008**	**2,029**	**3,981**
Total Requests Denied	3	1	3	**7**	**12**	**29**
Total Requests Pended/Extended	0	0	0	-	-	-
Total Requests Cancelled	0	0	0	-	-	-
% of Total Requests Denied	0.7%	0.3%	1.1%	**0.7%**	**0.6%**	**0.7%**

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 of 2018 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 interpretation services availability
        12. Member's letter includes nondiscriminatory notice.
        13. 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 3rd Quarter 2018

III. Findings

For the 4th quarter review of 2018, the findings are as follows:

A. For the dates of services and denials for October, of CY 2018 were pulled in the 4th quarter sampling year.
   a. 30 unique authorizations were pulled with a random sampling.
      i. 60% or 12/30 Medi-Cal LOB and 40% or 18/30 CMC LOB
      ii. 100% or 30/30 were denials
      iii. 33% or 10/30 were expedited request; 67% or 20/30 were standard request.
         1. 80% or 8/10 of the expedited authorizations are compliant with regulatory turnaround time of 72 calendar hours , 20% or 2/10 of the expedited authorizations are non compliant with regulatory turnaround time of 72 calendar hours ,
         2. 90% or 18/20 of the standard authorizations are compliant with regulatory turnaround time, 10% or 2/20 are non-compliant with regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB)
      iv. 67% or 20/30 are medical denials, 33% or 10/30 are administrative denials
      v. 100% or 30/30 of cases were denied by MD
      vi. 100% or 30/30 were provided member and provider notification.
      vii. 70% or 7/10 expedited authorizations were provided oral notifications to member.
      viii. 97% or 29/30 of the member letters are of member's preferred language.
      ix. 97% or 29/30 of the letters were readable and rationale for denial was provided.
      x. 100% or 29/30 of the letters included the criteria or EOC that the decision was based upon.
      xi. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact CMO or Medical Director.

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. Provide staff training regarding oral notification to member following an expedited service authorization determination.
2. Provide staff training in managing regulatory turnaround time based on LOB.
3. Provide staff training in quality quality monitoring including denial language and checking member's preferred language prior to sending member's UM letters.
4. Continue QA monitoring and reporting.

Santa Clara Family Health Plan

Referral Tracking Annual Report 2018

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

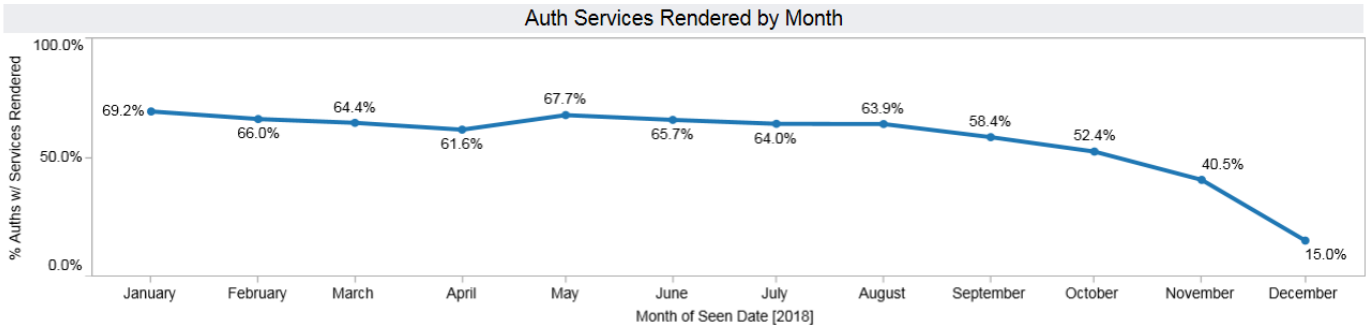
The report was completed for the rolling 12 month look back of:

- January 1 2018 to December 31 2018

FINDINGS:

1. There were 14,554 unique authorizations for all lines of business (roughly 1200 auths / month).
   - Cal MediConnect: 5126
     - 2297 without claims
   - Healthy Kids: 40
     - 19 without claims
   - Medi-Cal 9388
     - 3979 without claims

2. It was identified that there is an average 3 months claim lag time.
   - 53.5% Authorized services were rendered within 90 days of authorization.
   - 2.3% were rendered after 90 days of authorization.
   - 44.2% were not yet rendered to date.



3. Claims-Auths mis match were broken down into common type of service groups:

COMMON SERVICES	**NUMBER OF AUTHORIZATIONS WITH NO CLAIMS MATCH**	**% OF AUTHORIZATIONS WITH NO CLAIMS MATCH**
CBAS	41	0.65%
DME	600	9.53%
Home Health	314	4.99%
Outpatient	3790	60.21%
Continuity of Care	2	0.032%
Dental	39	0.62%
Transportation	1286	20.43%
Behavioral health	223	3.54%
Total	**6295**	**100 %**

FOLLOW UP

Follow up process interventions are initiated when identified via the fore-mentioned review process. Authorizations for the current year are pulled and a sampling of 10% or up to 50 outpatient specialty authorizations annually will result in a patient phone call to assess why a service was not received / no paid claim / or service was delayed. This will include medical and behavioral health care services, contracted and non-contracted provider.

1. 55 Unique case authorizations were pulled for sample calls.
    - 21 Cal MediConnect
    - 34 Medi-Cal
2. Types of services:
    - 1 EGD
    - 1 Home health
    - 7 MRI
    - 25 Outpatient therapy
    - 3 Sleep studies
    - 1 SBRT
    - 7 Transportation
    - 10 Other
3. 14 out of 55 cases confirmed that they received services already.
4. Reasons why member did not get service:
    - Member refuse service-1
    - Member is too sick to receive service-2
    - Scheduling issue-5
        - Taking care of family member, waiting for holidays to pass, member or provider scheduling issues

- Wants to talk to PCP prior to receiving service-1
- Service location issue-2

5. 30 unreachable members to confirm reason for incomplete services.
6. Zero termed members

SUMMARY:

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 UM Committee.

2018 Q4 Nurse Advice Line Stats by LOB

10/01/2018 thru -12/31/2018

1. Call Volume summary by disposition

Medi-Cal: 2114 total calls to NAL

- Top two highest volume dispositions: See Provider within 24 hours & Home/Self Care

Healthy Kids: 56 total calls to NAL

- Top two highest volume dispositions: No services necessary & See Provider within 24 hours

Cal MediConnect: 94 total calls to NAL

- Top two highest volume dispositions: See Provider within 24 hours & See ED immediately

2. Highest volume for Triage Guidelines used for Call types

Medi-Cal:

- CareNet Health information only
- Influenza/Flu-Like symptoms
- Abdominal pain
- Fever
- Cough/URI

Healthy Kids:

- Croup
- Fever
- Abdominal pain, Vomiting with diarrhea

Cal MediConnect:

- Influenza/Flu-Like symptoms
- CareNet information only
- Cough/URI
- Abdominal or Pelvic Pain

Peer to Peer Annual Review Calendar Year (Year to Date) 2018

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 2018, there were 19 total requests for Peer to Peer Reviews.

All 19 cases were reviewed for compliance. 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 findings are as follows:

1. 84% (16/19) calls were completed with the SCFHP physician and the requesting physician.
2. 81% (13/16 cases) had documentation of the call in our QNXT system.

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 current findings are that the majority of the physician calls are completed. Only 3 calls were not returned. 2 of the cases have no notes, and one case was redirected successfully to Stanford Medical Center.

    c. SCFHP will reinforce the use of QNXT for the completion of P2P call notes within the original authorization.

Santa Clara
Family Health Plan

The Spirit of Care

CONFIDENTIALITY, CONFLICT OF INTEREST, AND NON-DISCRIMINATION AGREEMENT

Applicability

All Santa Clara Family Health Plan (SCFHP) employees and affiliates, including consultants; peer reviewers; members of the following committees: Quality Improvement, Pharmacy and Therapeutics, Utilization Management, Peer Review, and Credentialing.

Confidentiality Statement

Persons involved in the evaluation of quality of care must recognize that confidentiality is vital to the free and candid discussion necessary for effective peer review and quality improvement activities. Therefore, all persons are required to respect and maintain the confidentiality of all review discussions, deliberations, records, and other information generated in connection with these activities, and to make no voluntary disclosures of such information, except to persons authorized to receive it in the conduct of business.

Furthermore, participation in quality management activities is based upon the premise that every other SCFHP employee and affiliates will similarly preserve the confidentiality of these activities. All employees and affiliates are entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including actions necessitated by any breach or threatened breach of this agreement.

Conflict of Interest Statement

Any employee or affiliate, as defined above, who has a conflict of interest with respect to any matter being reviewed, shall report the conflict of interest either to the Department Manager or to the person requesting the peer review. An employee or affiliate shall be deemed to have a conflict of interest if he/she has 1) any involvement in the care of the plan member whose case is under review; 2) any fiduciary interest in or fiduciary relationship with the provider in question; or 3) any other involvement in the case which impairs his/her objectivity in performing the review.

All Committee members and affiliates with a conflict of interest shall refrain from participating in the peer review process and shall abstain from any proceeding of the committee in which such issues are raised for consideration. Committee members shall report conflict of interest to the committee chairperson and shall refrain from casting a committee vote on any issue related to a conflict of interest.

Non-Discrimination Statement

SCFHP employees and affiliates agree not to make credentialing and recredentialing decisions based solely on a practitioner's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

Agreement

I, the undersigned, have read and understand the above Confidentiality, Conflict of Interest, and Non-Discrimination Statements and agree to abide by these standards and requirements in the conduct of my responsibilities at/with Santa Clara Family Health Plan.

_____

Name (print)

_____ _____

Name (signature) Date

Santa Clara Family Health Plan™

UTILIZATION MANAGEMENT DASHBOARD FOR BEHAVIORAL HEALTH

Cal MediConnect:

	2018					
	Oct	Nov	Dec	Q4 2018	FY 18-19	YTD
Pre-Service Organization Determinations - BH						
Standard Part C						
# of Prior Authorization Requests Received	1	1	3	**5**	**16**	**41**
# of Prior Auth Requests Completed within 14 days	1	1	3	**5**	**16**	**40**
% of Timely Decisions made within 14 days	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**97.6%**
# Approved	1	1	3	**5**	**16**	**41**
# Denied	-	0	0	**-**	**-**	**-**
% Approved	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**100.0%**
# of Prior Authorization Notification Sent	1	1	3	**5**	**16**	**19**
# of Prior Authorization Notification Sent Within 14 Days	1	1	3	**5**	**16**	**19**
% timely notification of BH decision	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**100.0%**
Expedited Part C						
# of Prior Authorization Requests Received	0	0	1	**1**	**2**	**2**
# of Prior Auth Requests Completed within 72 Hours	0	0	1	**1**	**2**	**2**
% of Timely Decisions made within 72 Hours	n/a	n/a	100.0%	**100.0%**	**100.0%**	**100.0%**
# of Requests with Extensions	unavailable	unavailable	unavailable	**unavailable**	**unavailable**	**unavailable**
# Approved	0	0	1	**1**	**2**	**2**
# Denied	0	0	0	**-**	**-**	**-**
% Approved	n/a	n/a	0.0%	**0.0%**	**0.0%**	**0.0%**
# of Prior Authorization Notification Sent	0	0	1.0%	**0**	**101.0%**	**1**
# of Prior Authorization Notification Sent Within 72 hours	0	0	1.0%	**0**	**101.0%**	**1**
% timely notification of BH decision	n/a	n/a	100.0%	**100.0%**	**100.0%**	**100.0%**
Urgent Concurrent Organization Determinations						
# of Urgent Concurrent Requests Received	0	0	0	**-**	**-**	**-**
# of Urgent Concurrent Requests Completed within 24 Hours	0	0	0	**-**	**-**	**-**
% of Timely Decisions made within 24 Hours	n/a	n/a	n/a	**n/a**	**n/a**	**n/a**
# Approved	0	0	0	**-**	**-**	**-**
# Denied	0	0	0	**-**	**-**	**-**
% Approved	n/a	n/a	n/a	**n/a**	**n/a**	**n/a**
# of Prior Authorization Notification Sent	0	0	0	**-**	**-**	**-**
# of Prior Authorization Notification Sent Within 24 hours	0	0	0	**-**	**-**	**-**
% timely notification of BH decision	n/a	n/a	n/a	**n/a**	**n/a**	**n/a**
Post Service Organization Determinations						
# of Requests Received	9	2	2	**13**	**24**	**47**
# of Post Service Requests Completed within 30 Days	9	2	2	**13**	**24**	**47**
% of Timely Decisions made within 30 days	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**100.0%**
# of Requests with Extensions	unavailable	unavailable	unavailable	**unavailable**	**unavailable**	**unavailable**
# Approved	9	2	2	**13**	**24**	**47**
# Denied	0	0	0	**-**	**-**	**-**
% Approved	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**100.0%**
# of Prior Authorization Notification Sent	9	2	2	**13**	**24**	**25**
# of Prior Authorization Notification Sent Within 30 Days	9	1	1	**11**	**22**	**22**
% timely notification of BH decision	100.0%	50.0%	50.0%	**84.6%**	**91.7%**	**88.0%**

Medi-Cal:

	2018					
	Oct	Nov	Dec	Q4 2018	FY 18-19	YTD
Medical Authorizations - BH						
Routine Authorizations						
# of Routine Prior Authorization Requests Received	56	34	39	**129**	**264**	**593**
# of Routine Prior Authorization Requests Completed within 5 Business Days	55	31	37	**123**	**257**	**565**
% of Timely Decisions made within 5 Business Days of request	98.2%	91.2%	94.9%	**95.3%**	**97.3%**	**95.3%**
# of Prior Authorization Notification Sent	56	34	39	**129**	**264**	**312**
# of Prior Authorization Notification Sent Within 5 Business Days	56	34	38	**128**	**262**	**310**
% timely notification of BH decision	100.0%	100.0%	97.4%	**99.2%**	**99.2%**	**99.4%**
Expedited Authorizations						
# of Expedited Prior Authorization Requests Received	4	3	1	**8**	**16**	**29**
# of Expedited Prior Authorization Requests Completed within 72 Hours	4	3	1	**8**	**16**	**26**
% of Timely Decisions made within 72 Hours of request	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**89.7%**
# of Prior Authorization Notification Sent	4	3	1	**8**	**16**	**19**
# of Prior Authorization Notification Sent Within 72 hours	4	3	1	**8**	**16**	**18**
% timely notification of BH decision	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**94.7%**
Urgent Concurrent Review						
# of Urgent Concurrent Requests Received	0	0	0	-	-	-
# of Urgent Concurrent Requests Completed within 24 Hours of request	0	0	0	-	-	-
% of Timely Decisions made within 24 Hours of request	n/a	n/a	n/a	**n/a**	**n/a**	**n/a**
# of Prior Authorization Notification Sent	0	0	0			
# of Prior Authorization Notification Sent Within 24 hours	0	0	0			
% timely notification of BH decision	n/a	n/a	n/a	**n/a**	**n/a**	**n/a**
Restrospective Review						
# of Retrospective Requests Received	22	16	13	**51**	**98**	**137**
# of Retrospective Requests completed within 30 Calendar Days of request	22	16	13	**51**	**98**	**136**
% of Retrospective Reviews completed within 30 Calendar Days of request	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**99.3%**
# of Prior Authorization Notification Sent	22	16	13	**51**	**98**	**104**
# of Prior Authorization Notification Sent Within 30 Calendar days	22	16	13	**51**	**98**	**104**
% timely notification of BH decision	100.0%	100.0%	100.0%	**100.0%**	**100.0%**	**100.0%**
Denied Authorizations (Routine, Expedited, CCR, Retro)						
Total Requests Approved	82	53	59	**194**	**381**	**677**
Total Requests Denied	1	1	1	**3**	**6**	**12**
Total Requests Pended/Extended	0	0	0	-	-	-
Total Requests Cancelled	0	0	0	-	-	-
% of Total Requests Denied	1.2%	1.9%	1.7%	**1.5%**	**1.6%**	**1.7%**

BEHAVIORAL HEALTH

MILD TO MODERATE REFERRALS

CY 2018

- Medi-CAL only referrals sent from County Call Center
- Authorizations for non-contracted providers for CY 2018:

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
10	19	12	17	21	3	10	29	8	10	15	10

BHT SERVICES

CY 2018

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
NA	185	184	189	194	200	186	197	202	207	219	224

- YTD TOTAL 202

TURNAROUND TIME:

URGENT

ROUTINE

DENIALS

BEHAVIORAL HEALTH TAGS:

California law requires the DMHC to conduct **a routine medical survey of each licensed full service and specialty health plan at least once every three years** specifically surrounding the following areas:

- Quality Assurance
- Grievances and Appeals (enrollee complaints)
- Access and Availability
- Utilization Management (referrals and authorizations)
- Overall plan performance in meeting enrollees' health care needs

A Technical Assistance Guide (TAG), is used by the surveyors to measure a health plan's performance and determine compliance. Each requirement listed will cite the statutory/regulatory citations, those to be interviewed in the survey, documents to be reviewed, and lists the key elements to meet the standards. TAG tools are updated as necessary based on legislative and regulation changes. DMHC has provided TAGS specific to Behavioral Health to help guide our program to ensure compliance.

DMHC FINDINGS UPDATE AND RECOMMENDATIONS

- Procedure QI.17.01 (Medically Necessary Behavioral Health Treatment Services/EPSDT) updated to reflect current APL 18-006

ASD EVALUATION OF TIMELY SCREENING AND DIAGNOSIS FOR CY 2018

- Please see PowerPoint

Developmental Screening

Update for screening improvements CY 2016-2017-2018

96110

1/10/2018

Current American Academy of Pediatric Recommendations

- The American Academy of Pediatrics (AAP) recommends that all children receive autism-specific screening at 18 and 24 months of age, in addition to the broad developmental screening **(Ages and Stages Questionnaire)** at 9, 18, and 24 months.
- Pediatric offices complete this in two stages:

✓ The Ages and Stages Questionnaires (ASQ) are a series of parent-completed child development screening tools, endorsed by the American Academy of Pediatrics. They are administered to the parents at (Child Health and Disability Prevention) CHDP visits ages (9-12)-(18-24)-30 months. The family completes the questionnaire and the pediatrician review/grade the questionnaire. If abnormal, they then refer family to local resources.

✓ Pediatricians also use the **M-CHAT (Modified Checklist for Autism in Toddlers)** in ages 16-30 months. Again parent completed. Scored with the provider and referrals made.

Update on the payment of the screening code:

- Starting July 2017, SCFHP pays the developmental screening code: 96110 as an additional fee-for-service payment if it billed with a (Child Health and Disability Prevention) CHDP visit.
  This is for Independent Network (10), PAMF (40), PMG (50), and PCNC (60).
- In CY 2018, SCFHP met actively with Healthier Kids foundation and First Five of Santa Clara County to help promote the use of age appropriate screening.
- The foundations have assisted some of the SCVHHS clinics with staff to complete screenings
- Health Education sent out a memo to providers and also included an article in the PCP news
- The results are as follows:

There has been a substantial increase in screenings in SCFHP Children

Developmental Screeing 96110 All Networks Claims and Encounters	
2016	134
2017	284
2018	2817