Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, April 20, 2022, 6:00-7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave., San Jose, CA 95119

Via Teleconference Only
(669) 900-6833
Meeting ID: 814 9920 8871
Passcode: **umc042022**
https://us06web.zoom.us/j/81499208871

AGENDA

1. Introduction	Dr. Lin	6:00	5 min
2. 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. Lin	6:05	5 min
3. Meeting Minutes Review minutes of the Q1 January 19, 2022 Utilization Management Committee (UMC) meeting. **Possible Action:** Approve Q1 2022 UMC Meeting Minutes	Dr. Lin	6:10	5 min
4. Chief Executive Officer Update Discuss status of current topics and initiatives.	Ms. Tomcala	6:15	5 min
5. Chief Medical Officer Update	Dr. Nakahira	6:20	5 min
6. Old Business/Follow-Up Items **a.** NCQA Cardiovascular Monitoring of People with Cardiovascular Disease and Schizophrenia	Dr. Huynh	6:25	2 min
7. UM Program Evaluation – 2021 Annual review of UM Program Evaluation **Possible Action:** Approve UM Program Evaluation	Dr. Boris	6:27	10 min
8. UM Work Plan – 2022 Annual review of UM Work Plan **Possible Action:** Approve Annual UM Work Plan	Dr. Boris	6:37	5 min
9. Prior Authorization Grid for Medi-Cal and Dual SNP - 2023 Overview of Prior Authorization Grid for Medi-Cal and Dual SNP 2023 **Possible Action:** Approve Prior Authorization Grid for Medi-Cal and Dual SNP	Dr. Huynh	6:42	3 min

10. UM 1B Annual Assessment of Senior Level Practitioners for NCQA - 2021 Review of 1B Annual Assessment of Senior Level Practitioners for NCQA.	Dr. Boris	6:45	5 min
11. Delegation Oversight UM Program for all Delegates - Medi-Cal **Possible Action:** Approve Delegation Oversight UM Program for All Medi-Cal Delegates.	Dr. Huynh	6:50	10 min
12. Enhanced Care Management (ECM) **a.** ECM Denial and Disenrollment Policy Review the policy for Discontinuation for ECM Services **b.** ECM Care Coordinator Guidelines Review of the ECM Care Coordinator Guidelines. **Possible Action:** Approve the ECM Denial and Disenrollment Policy and Care Coordinator Guidelines.	Dr. Huynh	7:00	5 min
13. Reports			
a. Membership Report	Dr. Boris	7:05	5 min
b. Over/Under Utilization by Procedure Type/Standard UM Metrics			
c. Dashboard Metrics • Turn-Around Time – Q1 2022	Mr. Perez	7:10	10 min
d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q1 2022			
e. Cal MediConnect and Medi-Cal Annual Referral Tracking - 2021 Annual Assessment			
f. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q1 2022	Dr. Huynh	7:20	2 min
g. Behavioral Health UM	Ms. Chen	7:22	8 min
14. Adjournment Next meeting: July 20, 2022 at 6:00 p.m.	Dr. Lin	7:30	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Utilization Management Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The 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 Amy O'Brien 48 hours prior to the meeting at (408) 874-1997.
- To obtain a copy of any supporting document that is available, contact Amy O'Brien at (408) 874-1997. 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.

Santa Clara Family Health Plan™

Public Comment

Santa Clara Family Health Plan™

Meeting Minutes

January 19, 2022

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, January 19, 2022, 6:00 – 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

Members Present
Jimmy Lin, M.D., Internal Medicine, Chair
Ali Alkoraishi, M.D., Psychiatry
Ngon Hoang Dinh, Head & Neck
Laurie Nakahira, D.O., Chief Medical Officer
Indira Vemuri, Pediatric Specialist

Members Absent
Habib Tobbagi, PCP, Nephrology
Dung Van Cai, D.O., OB/GYN

Staff Present
Christine Tomcala, Chief Executive Officer
Lily Boris, M.D., Medical Director
Natalie McKelvey, Manager, Behavioral Health
Luis Perez, Supervisor, Utilization Management
Ashley Kerner, Manager, Administrative Services
Amy O'Brien, Administrative Assistant

Note: Items were discussed in a different order than the agenda.

1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:08 p.m. Roll call was taken and a quorum was not established. Ashley Kerner, Manager, Administrative Services, introduced herself to the committee members.

2. Public Comment

There were no public comments.

3. Chief Executive Officer Update

Christine Tomcala, Chief Executive Officer, presented an update on 2 new programs which took effect on January 1, 2022. Ms. Tomcala began with the status of the CalAIM Medi-Cal (MC) reform program. The rollout of Enhanced Case Management (ECM) and community supports programs will continue over the next several years. Ms. Tomcala acknowledged the hard work of the UM team as they prepare for the implementation of these new programs. So far, the transition is going well. Ms. Tomcala also gave an update on the MC Rx program. This transition has been more of a challenge and has seen a few hiccups, such as long wait times for members trying to contact Magellan, the prescription provider.

Ms. Tomcala also gave an update on COVID. Due to the Omicron variant, the public health emergency has been extended. The SCFHP main office is not officially open yet; however, the Blanca Alvarado Community Resource Center is open to the public. SCFHP's efforts to increase members' vaccination rates continue, as they are approximately 20% lower than the overall rate of Santa Clara County.

Dr. Lin asked for the vaccination rate of SCFHP staff. Ms. Tomcala replied that approximately 90% of SCFHP staff are vaccinated. Dr. Lin remarked that the majority of patients hospitalized with COVID are unvaccinated.

Ms. Tomcala concurred and stated that vaccination helps relieve some of the more severe symptoms, in addition to keeping people out of the hospital. Dr. Lin also noted that COVID treatment options are better now than when the pandemic started and Ms. Tomcala agreed. She also discussed the possibility that a 4th booster shot may be necessary similar to the recommended annual flu shot.

4. Chief Medical Officer Update

a. General Update

Dr. Laurie Nakahira, Chief Medical Officer, began with an update on the rollout of the Medi-Cal Rx program. Members did experience extended wait times when trying to reach Magellan regarding their prescriptions. Fortunately, the UM team has a back line to Magellan to help members connect and receive their prescriptions. A Magellan representative reached out to the UM department regarding prior authorizations for controlled substances. These prior authorizations may require resubmission. The UM team was not previously aware of this requirement, and they are in the process of confirming this expectation in order to notify our provider network.

Dr. Nakahira advised the committee that the Plan is currently preparing for the National Committee for Quality Assurance (NCQA) reaccreditation audit for our Cal MediConnect (CMC) line of business. The onsite portion of the audit runs from January 31, 2022 through February 1, 2022. The Department of Health Care Services (DHCS) audit occurs mid-March of 2022, and will take place over a 2 week period.

Dr. Nakahira also discussed the student behavioral health incentive program. Over the next 3 years, the Plan will partner with the County Office of Education, Anthem, and the County Behavioral Health Department to work with the school districts to develop programs to support students' behavioral health. The Plan has received money to help implement these new incentive programs throughout the school districts.

Dr. Lin discussed the fact that the Medi-Cal Rx program will not accept any handwritten prescriptions for narcotics. Dr. Lin was dismayed to find out that it is actually all prescriptions that must be submitted via e-prescribe. Dr. Nakahira confirmed that, prior to the Medi-Cal Rx rollout, the medical board sent email notifications to all individual providers to notify them of this change.

b. Annual Confidentiality Agreements

Dr. Nakahira reminded the committee to promptly sign and return the Annual Confidentiality Agreement to Amy O'Brien.

5. Old Business Update

a. COVID-19 Reporting

Dr. Boris gave an update on the number of COVID-related deaths within the Plan's member populations for 2020, 2021, and 2022.

6. Reports

a. Membership

Dr. Boris gave a brief summary of the Membership Report from January 2021 through January 2022. Our CMC membership continues to grow with 10,219 members as of January 2022. Due to changes in CMC eligibility requirements, approximately 200 members were dis-enrolled as of January 1, 2022. The Plan's total MC membership is 284,439 members, an increase of approximately 21,346 members. The majority of these members are with Valley Health Plan. The Plan's direct membership includes 18,367 members. The Plan also manages the Admin. MC only and Admin. Medicare primary groups. NEMS is a new network provider group which began in October of 2021.

b. Over/Under Utilization by Procedure Type/Standard UM Metrics

Dr. Boris presented the Committee with the UM goals and objectives, as well as our Over/Under Utilization and Standard UM Metrics. Dr. Boris advised that these metrics cover the period from January 1, 2021

through December 31, 2021. Dr. Boris gave a summary of the data for the Plan's MC SPD line of business. The number of discharges per thousand is 14.32, with an average length of stay of 5.36 days. There does not appear to be a significant increase due to COVID. Dr. Boris continued with a summary of the data for the Plan's MC non-SPD line of business. The number of discharges per thousand is 3.91, with an average length of stay of 4.32 days. This population does not include our seniors or persons with disabilities.

Dr. Boris then gave a summary of the data for the Plan's CMC line of business. The number of discharges per thousand is 19.14, with an average length of stay of 5.82 days. This line of business includes the Plan's more high risk population.

Dr. Boris continued with a comparison of the inpatient utilization rates for the Plan's MC non-SPD and SPD populations. Dr. Boris also summarized the inpatient readmissions rates for the MC line of business. MC readmissions rates are monitored closely, as per Medicare performance standards and the SCFHP goal to reduce the likelihood of patient treatment errors and morbidity and mortality rates. Dr. Lin remarked that the 10% readmission rate for our CMC population is not out of line, however, he wants to know why the younger MC population readmission rate is so high. Dr. Boris explained that the MC program covers members in the 18-64 age group but, for the purposes of this report, the younger members have been omitted. Dr. Boris advised Dr. Lin that the number of chronic illnesses within the MC-SPD population is higher than you think. Ms. Tomcala asked if this presentation includes the HEDIS benchmarks. Dr. Boris replied that they were inadvertently left out of this presentation.

Dr. Vemuri joined the meeting at 6:27 p.m.

Dr. Boris continued with an overview of the ADHD MC BH metrics. The 2021 rankings for the Initiation Phase and Continuation Phase are not yet finalized. For purposes of the NCQA standards, the UM department prefers these fall within the 50th percentile. Dr. Boris discussed the UM department's ranking for cardiovascular monitoring of people with cardiovascular disease and schizophrenia. As always, it is a challenge to achieve more than a 10th percentile ranking. Dr. Lin remarked that he would expect a higher number of patients in this category would be more diligent in taking their medications. Dr. Boris explained that, due to their behavioral health diagnosis, they are at higher risk for cardiovascular disease. Dr. Alkoraishi added that it is a Food and Drug Administration (FDA) requirement that patients in this category have a lipid blood panel and fasting blood sugar every 6 months. Dr. Boris advised she will research the NCQA requirements and bring the results to the April 2022 meeting.

Dr. Dinh joined the meeting at 6:34 p.m.

7. Meeting Minutes

The minutes of the October 20, 2021 Utilization Management Committee (UMC) meeting were reviewed. Dr. Lin noted a correction to Dr. Dinh's specialty. Dr. Dinh is a head and neck specialist, rather than an OB/GYN as is currently shown. Dr. Boris confirmed that the minutes will be edited to reflect this change.

It was moved, seconded, and the minutes of the October 20, 2021 UMC meeting were **unanimously approved** with the change noted.

Motion:	Dr. Lin
Seconded:	Dr. Alkoraishi
Ayes:	Dr. Alkoraishi, Dr. Dinh, Dr. Lin, Dr. Nakahira, Dr. Vemuri
Absent:	Dr. Cai, Dr. Tobbagi

8. UM Program Description - 2022

Dr. Boris presented an overview of the UM Program Description for 2022. Dr. Boris advised this program description is a mandatory requirement for all of the Plan's regulators. Dr. Boris highlighted any significant changes, such as on page 11, item e) Pharmacy Director, and an internal error on page 22, E. Transplants, and the verbiage 'Renal and corneal transplants are excluded from SCFHP review' which will be stricken from the Program Description.

It was moved, seconded, and the UM Program Description - 2022 was **unanimously approved** with the change as noted.

Motion: Dr. Lin
Seconded: Dr. Alkoraishi
Ayes: Dr. Alkoraishi, Dr. Dinh, Dr. Lin, Dr. Nakahira, Dr. Vemuri
Absent: Dr. Cai, Dr. Tobbagi

9. BHT Program Description - 2022

Natalie McKelvey, Manager, Behavioral Health, presented an overview of the BHT Program Description – 2022. This program description is an NCQA requirement and includes an update to some of the codes. There has been no update to the criteria for the treatment plan or goals. Ms. McKelvey highlighted the changes to the codes for H0032 – Supervision (Direct) and H0032 – Supervision (Indirect).

Dr. Vemuri asked if, as a Pediatrician, she is authorized to make a diagnosis of autism. Ms. McKelvey advised that a pediatrician is authorized to make this diagnosis, and to address specific behaviors that may lead to a diagnosis of autism. Dr. Vemuri advised she has made this diagnosis in the past and it has been denied because she is not a psychologist. Ms. McKelvey suggested she address specific behaviors in her referral that would lead to a recommendation of ABA therapy. Ms. McKelvey will reach out to Dr. Vemuri outside of this meeting to further discuss. Dr. Alkoraishi suggested Dr. Vemuri consult the DSM V or ICD-10 codes. Dr. Boris advised that the UM team will review and target their reporting to search for ABA therapy denials for children and confirm they are SCFHP members and should receive ABA therapy.

It was moved, seconded, and the BHT Program Description - 2022 was **unanimously approved**.

Motion: Dr. Lin
Seconded: Dr. Alkoraishi
Ayes: Dr. Alkoraishi, Dr. Dinh, Dr. Lin, Dr. Nakahira, Dr. Vemuri
Absent: Dr. Cai, Dr. Tobbagi

10. Annual Review of UM Policies

a. HS.01 Prior Authorization
b. HS.02 Medical Necessity Criteria
c. HS.03 Appropriate Use of Professionals
d. HS.04 Denial of Services Notification
e. HS.05 Evaluation of New Technology
f. HS.06 Emergency Services
g. HS.07 Long-Term Care Utilization Review
h. HS.08 Second Opinion
i. HS.09 Inter-Rater Reliability
j. HS.10 Financial Incentive
k. HS.11 Informed Consent
l. HS.12 Preventive Health Guidelines
m. HS.13 Transportation Services
n. HS.14 System Controls

Dr. Boris presented the Committee with the annual review of UM Policies. Dr. Boris summarized the purpose of these policies. There were no changes to these policies since the January 2021 meeting.

It was moved, seconded, and the Annual Review of UM Policies was **unanimously approved**.

Motion: Dr. Lin
Seconded: Dr. Alkoraishi
Ayes: Dr. Alkoraishi, Dr. Dinh, Dr. Lin, Dr. Nakahira, Dr. Vemuri
Absent: Dr. Cai, Dr. Tobbagi

11. Care Coordinator Guidelines

a. Review of New Care Coordinator Guidelines

Luis Perez, Supervisor, Utilization Management, presented the committee with an overview of the new care coordinator guidelines. Dr. Lin asked how many of our members are in long-term care. Dr. Boris replied that she will research this information and bring the results to the April 2022 meeting. Dr. Boris believes the number is stable since our October 2021 meeting.

Mr. Perez continued his presentation. Dr. Lin asked for clarification of the guidelines for hospice room and board for non-contracted providers. Dr. Boris advised that these guidelines are specific to hospice care conducted within a Skilled Nursing Facility (SNF), which is a rare circumstance.

b. Community Based Adult Services (CBAS)

Mr. Perez gave an update on CBAS. Dr. Lin asked if CBAS was once run by the County, and Dr. Boris replied that, prior to 2015, management of this benefit was transferred to SCFHP. Dr. Boris and Mr. Perez agreed that there were no changes to the Care Coordinator Guidelines specific to CBAS.

It was moved, seconded, and the Care Coordinator Guidelines were **unanimously approved.**

Motion:	Dr. Lin
Seconded:	Dr. Alkoraishi
Ayes:	Dr. Alkoraishi, Dr. Dinh, Dr. Lin, Dr. Nakahira, Dr. Dinh, Dr. Vemuri
Absent:	Dr. Cai, Dr. Tobbagi

12. Reports

c. Dashboard Metrics

- Turn-Around Time – Q4 2021

Mr. Perez summarized the CMC Turn-Around Time metrics for Q4 2021. The turn-around times in almost all categories are compliant at 98.4% or better, with many categories at 100%. In the category of Part B Drugs Expedited Prior Authorization Requests, Q4 2021 fell short at 92%. Mr. Perez continued with a summarization of the MC Turn-Around Time metrics for Q4 2021. The turn-around times in the majority of MC categories are compliant at 98.0%, with many categories at 100%.

Dr. Vemuri left the meeting at 6:40 p.m.

d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q4 2021

Dr. Boris summarized the data from the Q4 2021 CMC Quarterly Referral Tracking reports for the Committee. Dr. Boris explained the purpose of the quarterly referral tracking reports. At the end of the year, the Plan analyzes the members who did not receive authorized services to determine why those services were not rendered. This is a requirement of the DHCS. Dr. Boris explained that these numbers are affected by claims lag times.

Dr. Boris continued and summarized the data from the Q4 2021 MC Quarterly Referral Tracking report. Dr. Boris reiterated that these numbers are affected by the expected claims lag times. Dr. Lin and Dr. Boris agreed that many services were likely not rendered due to COVID.

e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q4 2021

Dr. Boris presented the results of the Q4 2021 Quality Monitoring of Plan Authorizations and Denial Letters from October 1, 2021 through December 31, 2021. Dr. Boris reported that the UM department received a 100% score in all categories. All findings are reviewed on a quarterly basis, with oversight by the Plan's medical directors. The Plan also continues to review our delegated letters, as those pertain to delegates with corrective action plans.

f. Delegation Oversight Dashboard

Dr. Boris presented a snapshot of the Delegation Oversight Dashboard to the committee. Dr. Boris explained the purpose and goal of the delegation dashboard. Dr. Boris highlighted the process the Plan follows to monitor their delegated groups. The Plan's auditors also require that the Plan show compliance with corrective action plans.

g. Annual Physician Peer-to-Peer (HS.02.02) – 2021

Dr. Boris next presented an overview of the Annual Physician Peer-to-Peer review. This process was initially in response to a prior DHCS request; however, the Plan chose to continue with this process. Dr. Boris explained the purpose and goal of Peer-to-Peer review, as well as the process to track Peer-to-Peer requests. The process begins when either she, Dr. Robertson, or Dr. Nakahira issue a denial letter. All denial letters clearly state physicians' and medical groups' peer-to-peer review rights, along with the telephone number to call to start the process. In cases where the initial denial was upheld, physicians and medical groups are advised to appeal.

h. Behavioral Health (BH) UM

Ms. Natalie McKelvey, Manager, BH, gave an overview of the BHT program for the committee. Ms. McKelvey highlighted the screenings that the BH team completed. These screening numbers may be affected by a claims lag. Ms. McKelvey highlighted the fact that outpatient utilization for our CMC line of business appears to have decreased, and she will research why this is the case. It may be attributable to a billing issue. Ms. Tomcala pointed out that our CMC population may be less comfortable using telehealth. Ms. McKelvey agreed, and she also advised that the County has a back log of residents who request services. Dr. Lin advised that, for the mild-to-moderate cases, primary care physicians should be able to render treatment. Ms. McKelvey advised that these claims are specific to our psychotherapists and BH treatment providers. Dr. Alkoraishi remarked that his patient no show rate has decreased which he attributes to the ease and convenience of appointments via telehealth and FaceTime.

Ms. McKelvey continued with her presentation. Kaiser continues to do a good job with getting their mild-to-moderate patients in treatment. Ms. Tomcala circled back to the low outpatient utilization rate, and she suggests we ask our Independent Practitioner Association (IPAs) for their thoughts on why utilization is so much lower per thousand. Ms. McKelvey replied that feedback from our IPAs suggests they are unaware of the resources available to connect patients with outpatient treatment. Ms. McKelvey will continue to meet with IPA leadership to try to close this gap.

Dr. Nakahira advised this may be attributable to a cultural difference. Ms. McKelvey responded that it may also be due to capitation, as BH is not included. Ms. McKelvey continued with her presentation on BH treatment, which is specific to ABA, and does not include supplemental treatments. Kaiser continues to have the highest rate of patients in treatment. Dr. Lin asked why Kaiser is able to see so many patients. Ms. McKelvey replied that Kaiser has a good developmental screenings process, in conjunction with a smooth referral process. Ms. McKelvey concluded with a discussion of the projects she is working on for 2022.

13. Adjournment

The meeting adjourned at 7:44 p.m. The next meeting of the Utilization Management Commitment is on April 20, 2022 at 6:00 p.m.

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Jimmy Lin, M.D, Chair
Utilization Management Committee

Date

Santa Clara Family Health Plan™

Chief Executive Officer Update

Santa Clara Family Health Plan™

Chief Medical Officer Update

Santa Clara Family Health Plan™

Old Business/Follow-Up Items

NCQA Cardiovascular Monitoring of People with Cardiovascular Disease and Schizophrenia

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.

Eligible Population

Product lines Medicaid.

Ages 18–64 years as of December 31 of the measurement year.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefits Medical.

Event/diagnosis Follow the steps below to identify the eligible population.

Step 1 Identify members with schizophrenia or schizoaffective disorder as those who met at least one of the following criteria during the measurement year:

- At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder. Either of the following code combinations meets criteria:
  - BH Stand Alone Acute Inpatient Value Set ***with*** Schizophrenia Value Set.
  - Visit Setting Unspecified Value Set ***with*** Acute Inpatient POS Value Set ***with*** Schizophrenia Value Set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or schizoaffective disorder. Two of any of the following meets criteria:
  - An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set ***with*** Schizophrenia Value Set).

- An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (BH Outpatient Value Set ***with*** Schizophrenia Value Set).
- An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set ***with*** Schizophrenia Value Set.
- An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Partial Hospitalization or Intensive Outpatient Value Set ***with*** Schizophrenia Value Set).
- A community mental health center visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set ***with*** Schizophrenia Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An observation visit (Observation Value Set) ***with*** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An ED visit (ED Value Set) ***with*** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An ED visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set ***with*** ED POS Value Set ***with*** Schizophrenia Value Set).
- A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) ***with*** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- A nonacute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set ***with*** Nonacute Inpatient POS Value Set ***with*** Schizophrenia Value Set).
- A telehealth visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set ***with*** Schizophrenia Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).

Step 2 Identify members from step 1 who also have cardiovascular disease. Members are identified as having cardiovascular disease in two ways: by event or by diagnosis. The organization must use both methods to identify the eligible population, but a member need only be identified by one to be included in the measure.

Event. Any of the following during the year prior to the measurement year meet criteria:

- *AMI*. Discharged from an inpatient setting with an AMI diagnosis (AMI Value Set) on the discharge claim. To identify discharges:

  - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

- Identify the discharge date for the stay.

- *CABG*. Members who had CABG (CABG Value Set) in any setting.
- *PCI*. Members who had PCI (PCI Value Set) in any setting.

Diagnosis. Identify members with IVD as those who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one outpatient visit (Outpatient Value Set) with a diagnosis of IVD (IVD Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** any diagnosis of IVD (IVD Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** any diagnosis of IVD (IVD Value Set).
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of IVD (IVD Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a diagnosis of IVD (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.

Required exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator

LDL-C Test An LDL-C test (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) performed during the measurement year.

The organization may use a calculated or direct LDL.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SMC-1: Data Elements for Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

Metric	Data Element	Reporting Instructions
CardiovascularMonitoringSchizophrenia	EligiblePopulation	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	NumeratorBySupplemental	Report once
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing denominator age range is allowed within a specified age range (ages 18 and older).
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits and diagnosis. VSDs and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
LDL-C test	No	Value sets and logic may not be changed.

Santa Clara Family Health Plan™

UM Program Evaluation - 2021

Utilization Management Program Evaluation

CY 2021

Presented to UMC: April 20, 2022

Cal MediConnect Line of Business (CMC) and Medi-Cal Lines of Business

Santa Clara Family Health Plan annually evaluates the Utilization Management (UM) program to ensure members receive appropriate care, follow trends in utilization, identify needed improvements, assess progress toward goals and determine the overall effectiveness of the UM program. The annual evaluation serves as an invaluable tool to identify goals and opportunities for improvement that shape work plan activities for the coming year.

Program Structure which includes the Involvement of Senior Level physician and UM Program Structure

Oversight of the UM programs is delegated to the Chief Medical Officer (CMO) and the Quality Improvement Committee (QIC). 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

The CMO and QIC provide guidance and direction to enable SCFHP to identify resources and needs to carry out the UM program. The QIC receives quarterly UM Minutes and this info is directly provided to the Board of Directors who are responsible for approving the Quality Improvement (QI) and UM programs. The Board of Directors appoints and oversees the QIC. The QIC provides authority, direction, guidance and resources to the UMC to enable SCFHP staff to carry out the Quality Improvement and Utilization Management functions.

The UM Committee oversees implementation of the UM program. The UM Committee includes participating practitioners from a range of specialties, including behavioral health (please see minutes of

UMC for details of practitioners). The Committee also features internal staff who are knowledgeable about UM processes, including a BH manager.

The UM Committee meets quarterly in accordance with the SCFHP bylaws. Ad hoc meetings may be convened, as needed. UM Committee minutes summarize activities and decisions. Minutes are signed and dated. The UM program is presented to the QI Committee for final approval. The QIC provides recommendations and direction as part of the approval process.

The UM Committee is chaired by a senior level medical director. The UMC reviews, approves provides appropriate direction and feedback to a variety of UM activities including: UM Program Description, UM Evaluation, UM policies, Care Coordinator Guidelines, plan membership, UM data reports that are outlined in the UM Work Plan, UM Prior Authorization Grid, Inter-Rater Reliability (IRR) test results, Delegation Oversight, and Quality Monitoring reports. The QIC reviews and approves UMC minutes.

Program Scope

The UM Program is comprehensive and is designed to ensure members receive appropriate care. The program consists of systematic functions, services and processes that provide criteria-based medical necessity determinations regarding the appropriateness of care in accordance with the member's benefit coverage. UM policies and procedures reflect the use of these criteria, which are reviewed annually, to ensure that medical necessity is based on current medical information. Medical necessity reviews are conducted in a manner that meets timeliness requirements of regulatory bodies, including provisions for responding to clinically urgent situations. All medical necessity determinations are reviewed by qualified healthcare staff (pharmacist or medical directors). In addition the on a quarterly basis UMC is provided with a review of a sample of authorizations for quality monitoring in both the CMC and Medi-Cal lines of business. Samples of reviewed for accuracy of denial rationale, timeliness, consideration of the necessary guideline used or benefit determination by the clinical team and adequacy of the clinical data provided within the prior authorization / organizational determination documents. Please see quarterly HS.04.01 Quality Monitoring presented in each UMC meeting. Benefit coverage determinations are made by using the following information:

- Medicare Guidelines and Policy Manuals for CMC members
- Medi-Cal APL's (All Plan Policy Letters), TAR (Treatment Authorization Request) and Benefit Manuals

SCFHP monitors both quality of clinical care and quality of service measures to ensure members receive the appropriate type and level of care. Inpatient admissions are monitored against MCG inpatient goal length of stay criteria and national benchmarks. Inpatient utilization, average length of stay (ALOS) and Bed Days per 1000 are compared to MCG's Inpatient Care Utilization model reflecting a loosely managed plan. Readmission rates were also monitored. Over and Underutilization of services are also monitored on a quarterly basis by analysis of both claim and encounter data for all membership.

Please refer to attachment 1: UM Program Evaluation Grid for comprehensive data and metrics plus goals for the CY 2022 for CMC and Medi-Cal. This grid outlines all goals for CY 2022 both in clinical and non clinical areas (timeliness, quality, etc.). This evaluation is presented annually to the UMC and new goals are set annually.

The UMC has participation by the Chief Medical Officer, the Medical Director, and an physician in the field of psychiatry (a participating practitioner in the health and hospital system) on the committee. These practitioners are all directly involved in the development of the UM program. As outlined by the UMC minutes, they provide guidance and present materials for discussion at the UMC meetings.

Inter Rater Reliability (IRR) test is administered annually to assess the consistency with which clinical criteria are appropriately applied to approvals and denials of services. All UM staff (clinical and non-clinical as well as, the medical directors and CMO) and all Behavioral Health Staff are evaluated for several elements which include: 1. Do the staff know the line of business and required turnaround times for each line of business, 2. Can the staff identify the member, demographics, type of authorization and TAT applicable to that type, 3. For non-clinical staff, does the staff know how to apply the Care Coordinator guidelines, 4. Do the clinical staff know how to apply the appropriate guidelines (includes nursing staff, medical directors and behavioral health (BH) practitioners). The 2022 overall Inter-Rater Reliability (IRR) passing rate is approximately 92%.

The UM Program Description was updated to meet regulatory requirements and to ensure effectiveness of the program structure. Staff roles and assigned activities were reviewed throughout the year based on organizational workload and changes in benefits. More than 90% of the UM staff continue to work remotely during the time of COVID restrictions and have continued to perform all functions of the department.

The input of our members and practitioner experience is assessed annually at the UMC and any relevant results are used to update the UM program.

This input was presented to:

1. SCFHP used the CAHPS survey 2020 for CMC line of business
2. SCFHP used the CY 2021 Grievances against the SCFHP UM department to evaluate both member and practitioner feedback
3. SCFHP used the Physician Peer to Peer analysis as a marker of practitioner follow up

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

Medi-Cal

The NCQA HEDIS Consumer Assessment of Healthcare Providers & Systems (CAHPS) 5.0H Child and Adult Medicaid survey follows the DHCS direction of a 2-year cycle. The last CAHPS was conducted in MY2020, and the result was released in 2021.
Adult Medicaid Survey's total response rate is 18.6%.

Measure	Rate (8+9+10)	Rate (9+10)
Rating of the Health Plan	71.8%	53.31%
	Rate (Always)	Rate (Always + Usually)
Customer Service	63.02%	90.43%

Child Medicaid Survey's total response rate is 21.87%

Measure	Rate (8+9+10)	Rate (9+10)
Rating of the Health Plan	88.4%	72.85%
	Rate (Always)	Rate (Always + Usually)
Customer Service	60.76%	86.92%

SCFHP UM will use the CAHPS survey to educate the UM staff. These numbers are not specific to UM however, they do reflect a general trend and will be used in staff education.

For the CMC line of business, review of the CAHPS survey, shows that in 2021, the response rate was 33.5%, a 4.3% increase over the prior year. there were improvements in all member experience domains and ratings of the health plan from 2019 to 2020. Overall there were no significant changes compared to 2020. However there were moderate improvements and the gaps compared to 2019 results were closed in the following areas: Rating of Health Plan and Rating of Health Care Quality. The rating of the Health Plan was at 59.9%. And for CMC, the ease of filling prescriptions by mail showed a 5 point increase between 2019 and 2021.

Evaluation of specific complaints revealed that there are very few grievances against SCFHP UM Department. Member evaluation of grievances showed only 10 grievances for CY 2021 for both CMC and Medi-Cal (2020 had 5 grievances against UM however it only measured the CMC Line of Bsn). Review of the 10 issues show all are quality of service issues 6 MCAL and 4 CMC. The issues range from questioning the stamp date on the letter, the language on the auth, being upset about two denials of service, and requesting that an expedited request be processed by end of day (not 72 hours). No real trending issue. As such, this is not a statistically significant increase based on membership numbers.

Conclusion:

1. SCFHP had no provider grievances.
2. SCFHP will use the CAHPS survey as an opportunity for continued staff education.
3. The UM program, revisions are specific to changes in Medi-Cal Pharmacy becoming carved out to DHCS.
4. The ease of filling prescriptions by mail showed a 5 point increase between 2019 and 2021. Reflecting significant member satisfaction.

Goals for 2022:

The UM program will foster the provision of clinically appropriate care and will meet regulatory requirements as described in the UM Program Description. The 2022 UM Work Plan will serve as a guide to ensure program goals are met.

For CY 2022: in the areas of delegation and over and underutilization of services, the UM committee will be provided quarterly standard reports for review, discussion, and approval. This is an area of oversight which was traditionally under compliance, however, will now also have additional oversight by the UMC.

Conclusion:

For the CY 2021: The statistics in the UMC Meetings show continued >95% compliance on measures of timeliness and clinical quality for both CMC and Medi-Cal. The committee structure did not change. There continued to be both our CMO, Medical Director and our physician in BH committee member's active participation.

1. The UM program description is reviewed and approved by the SCFHP Utilization Management Committee (UMC) annually.
2. The SCFHP Chief Medical Officer or a medical director is involved in all UM activities, including implementation, supervision, oversight and evaluation of the UM Program.
3. Criteria and guidelines will be updated yearly based on current evidence-based information.

Santa Clara Family Health Plan™

UM Work Plan - 2022

Santa Clara Family Health Plan.

UTILIZATION MANAGEMENT WORKPLAN 2022

WORK PLAN

	SCOPE	OBJECTIVE	ACTION STEPS	GOAL	RESPONSIBLE PARTY	REPORT FREQUENCY
1	**Quality of Clinical Care**	Expand on Current reporting and present findings to UMC	Review Medi-Cal Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly
2	**Quality of Clinical Care**	Monitor appropriate inpatient admissions	Review CMC Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly
3	**Quality of Clinical Care**	Monitor appropriateness of inpatient stays to assess proper level of care	Review Medi-Cal Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly
4	**Quality of Clinical Care**	Monitor appropriateness of inpatient stays to assess proper level of care	Review CMC Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly
5	**Quality of Clinical Care**	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	Medi-Cal Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly
6	**Quality of Clinical Care**	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	CMC Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly
7	**Quality of Service**	Assess Medi-Cal denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Outpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly
8	**Quality of Service**	Assess CMC denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Inpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly
9	**Quality of Service**	Track and monitor denial rates on PARs; provide benchmarks and compare to CA specific plans	Track and monitor BH IP Stays for CMC	MCG and CA benchmarks	Medical Director	Quarterly
10	**Quality of Clinical Care**	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	Medi-Cal ADD Follow-up Care for Children with ADD	HEDIS Benchmarks	Manager of Behavioral Health	Quarterly
11	**Quality of Clinical Care**	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	Medi-Cal AMM Antidepressant Medication Management	HEDIS Benchmarks	Manager of Behavioral Health	Quarterly
12	**Quality of Clinical Care**	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	CMC SMC Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS Benchmarks	Manager of Behavioral Health	Quarterly
13	**Quality of Service**	Internal audit process and corrective action as necessary	Report Turn Around Times (TAT) for Prior Authorizations for Medi-Cal and CMC LOB	DHCS and CMS regulatory TAT	Manager of Utilization Management	Quarterly
14	**Quality of Service**	Internal audit process and corrective action as necessary	Report TAT based on priority for Medi-Cal and CMC	DHCS and CMS regulatory TAT	Manager of Utilization Management	Quarterly
15	**Quality of Service**	Annual IRR will be presented to the UMC	Assess and measure consistency of applying medical necessity criteria	80% passing rate	Manager of Utilization Management	Annually
16	**Quality of Service**	Monitor Member and Provider experience	Conduct Member & Provider satisfaction survey	90% Satisfaction	Manager of Utilization Management	Annually
17	**Quality of Clinical Care**	UM Program Description	UM Program Description will be adopted on an annual basis	Adoption	Health Services Director	Annually
18	**Quality of Clinical Care**	Annual Evaluation of Utilization Management Program will be reviewed and updated	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	Revisions/Adoption	Manager of Utilization Management	Annually
19	**Quality of Clinical Care**	Implement a UM program which utilizes medical necessity decisions consistently, are objective and based upon evidence based criteria	Annually review and approve Medical Necessity Criteria policy	Review and Adoption	Manager of Utilization Management	Annually
20	**Quality of Service**	Implement a UM program which provides access to staff for members and practitioners seeking information about the UM process and authorization of care	Annually review and approve Communication with Health Services Procedure	Review and Adoption	Manager of Utilization Management	Annually
21	**Quality of Clinical Care**	Implement a UM program which utilizes qualified health professionals to assess clinical information to support UM decisions	Annually review and approve Appropriate Use of Professionals policy	Review and Adoption	Manager of Utilization Management	Annually
22	**Quality of Clinical Care**	Implement a UM program which determines coverage based on medical necessity.	Annually review and approve Prior Authorization Procedure for clinical information	Review and Adoption	Manager of Utilization Management	Annually
23	**Quality of Service**	Delegation Oversight	Quarterly Review of Areas under corrective action plan	Review and Feedback on Process Improvement	UMC	Quarterly
24	**Quality of Clinical Care**	Delegation Oversight	Review Quarterly Delegation reports	HEDIS , National and State Benchmarks	Manager of Utilization Management	Quarterly

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Prior Authorization Grid for Medi-Cal and Dual SNP - 2023

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Medical Benefit Drug Prior Authorization Grid

The following drugs require prior authorization for all Santa Clara Family Health Plan members. Additional required actions, restrictions, or limits on use are indicated in the right column.

Abbreviations used in this document include:

ST: Step Therapy
PA: Prior Authorization

Brand	Generic	Necessary Actions, Restrictions, or Limits on Use
ANTIEMETICS (ASSOCIATED WITH CANCER CHEMOTHERAPY)		
Cinvanti	Aprepitant	PA
Emend IV	Fosaprepitant	PA
Aloxi	Palonosetron	PA
Akynzeo IV	Fosnetupitant/Palonosetron	PA
ANTIHEMOPHILIC AGENTS		
Hemlibra	Emicizumab-kxwh	PA
CAR-T CELL IMMUNOTHERAPY		
Yescarta	Axicabtagene ciloleucel	PA
Tecartus	Brexucabtagene autoleucel	PA
Kymriah	Tisagenlecleucel	PA
Abecma	Idecabtagene vicleucel	PA
Breyanzi	Lisocabtagene maraleucel	PA
ERYTHROPOIESIS STIMULATING AGENTS		
Aranesp	Darbepoetin alfa	PA, ST: Retacrit
Epogen, Procrit	Epoetin alfa	PA, ST: Retacrit
Retacrit	Epoetin alfa-epbx	PA
Mircera	Methoxy polyethylene glycol-epoetin beta	PA, ST: Retacrit
COLONY STIMULATING FACTORS		
Neupogen	Filgrastim	PA, ST: Zarxio or Nivestym
Neulasta, Neulasta OnPro	Pegfilgrastim	PA, ST: Fulphila, Udenyca, Ziextenzo, or Nyvepria
Granix	Tbo-filgrastim	PA, ST: Zarxio or Nivestym
Leukine	Sargramostim	PA, ST: Zarxio, Nivestym, Fulphila, Udenyca, Ziextenzo, or Nyvepria
GAUCHER DISEASE		
Cerezyme	Imiglucerase	PA
Elelyso	Taliglucerase alfa	PA
Vpriv	Velaglucerase alfa	PA

Brand	Generic	Necessary Actions, Restrictions, or Limits on Use
HEREDITARY ANGIOEDEMA		
Berinert, Cinryze, Haegarda	C1 esterase inhibitor, human	PA
Ruconest	C1 esterase inhibitor, recombinant	PA
Kalbitor	Ecallantide	PA
Firazyr	Icatibant	PA
Takhzyro	Lanadelumab-flyo	PA
IV IMMUNOGLOBULIN (IVIG)		
Asceniv, Bivigam, Carimune NF, Cutaquig, Cuvitru, Flebogamma DIF, GamaSTAN, GamaSTAN S/D, Gammagard, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, Hyqvia, Octagam, Panzyga, Privigen, Xembify	Immune globulin, Immune globulin lyophilized, Immune globulin non-lyophilized	PA
MULTIPLE SCLEROSIS		
Tysabri	Natalizumab	PA
Ocrevus	Ocrelizumab	PA
NEUROMUSCULAR BLOCKING AGENTS		
Dysport	AbobotulinumtoxinA	PA
Xeomin	IncobotulinumtoxinA	PA
Botox	OnabotulinumtoxinA	PA
Myobloc	RimabotulinumtoxinB	PA
OPHTHALMIC AGENTS		
Beovu	Brolucizumab-dbll	PA, ST: Bevacizumab
Eylea	Aflibercept	PA, ST: Bevacizumab
Lucentis	Ranibizumab	PA, ST: Bevacizumab
Susvimo	Ranibizumab	PA, ST: Bevacizumab
Byooviz	Ranibizumab-nuna	PA, ST: Bevacizumab
Visudyne	Verteporfin	PA
Luxturna	Voretigene neparvovec-rzyl	PA
PULMONARY HYPERTENSION		
Flolan, Veletri	Epoprostenol	PA
Remodulin IV	Treprostinil	PA

Brand	Generic	Necessary Actions, Restrictions, or Limits on Use
RESPIRATORY		
Aralast NP, Glassia, Prolastin-C, Zemaira	α-1 proteinase inhibitor	PA
Fasenra	Benralizumab	PA
Nucala	Mepolizumab	PA
Xolair	Omalizumab	PA
Synagis	Palivizumab	PA
Cinqair	Reslizumab	PA
RHEUMATOLOGY/IMMUNOSUPPRESSANTS		
Orencia IV	Abatacept	PA
Humira, Cyltezo, Abrilada, Amjevita, Hyrimoz, Hadlima, Hulio	Adalimumab, Adalimumab-adbm, Adalimumab-afzb, Adalimumab-atto, Adalimumab-adaz, Adalimumab-bwwd, Adalimumab-fkjp	Pharmacy Benefit Only
Cimzia	Certolizumab pegol	Pharmacy Benefit Only
Enbrel, Erelzi, Eticovo	Etanercept, Etanercept-szzs, Etanercept-ykro	Pharmacy Benefit Only
Simponi Aria	Golimumab	PA
Tremfya	Guselkumab	PA
Remicade	Infliximab	PA, ST: Inflectra, Renflexis, Ixifi, or Avsola
Inflectra, Renflexis, Ixifi, Avsola	Infliximab-dyyb, Infliximab-abda, Infliximab-qbtx, Infliximab-axxq	PA
Taltz	Ixekizumab	Pharmacy Benefit Only
Rituxan, Rituxan Hycela	Rituximab, Rituximab/hyaluronidase	PA, ST: Truxima, Ruxience, or Riabni
Truxima, Ruxience, Riabni	Rituximab-abbs, Rituximab-pvvr, Rituximab-arrx	PA
Actemra IV	Tocilizumab	PA
Stelara IV	Ustekinumab	PA
Entyvio	Vedolizumab	PA
MISCELLANEOUS		
Exondys 51	Eteplirsen	PA
Spinraza	Nusinersen	PA
Onpattro	Patisiran	PA
Krystexxa	Pegloticase	PA
Nplate	Romiplostim	PA
Radicava	Edaravone	PA

Brand	Generic	Necessary Actions, Restrictions, or Limits on Use
MISCELLANEOUS, CONTINUED		
Zolgensma	Onasemnogene abeparvovec-xioi	PA
Tepezza	Teprotumumab-trbw	PA
Vyepti	Eptinezumab-jjmr	PA
Aduhelm	Aducanumab	PA
UNCLASSIFIED		
Unclassified drugs and biologics		PA

Santa Clara Family Health Plan™

UM 1B Annual Assessment of Senior Level Practitioners for NCQA - 2021

SCFHP annually assesses the senior level practitioner involvement in all activities related to UM. This includes both Medical and Behavioral Health components of the UM process.

The following activities were completed with both senior level practitioners on a quarterly basis in UM.

1. What committees does the senior level practitioner chair for UM?

- The UM Medical Director, Dr. Lily Boris, co-chairs the UMC committee with our committee practitioner, Dr. Jimmy Lin. In addition, the UMC has Dr. Ali Alkorashi, Psychiatry, on the committee.
- The UM Committee met on a quarterly basis in CY 2021 on the following dates: January 20, April 21, July 21, and Oct 20 – 2020.
- As per the minutes, all three providers, Dr. Lin, Dr. Boris, and Dr. Alkorashi were, and continue to be, active participants in these meetings.

Senior Level Practitioner

2. Are the senior level practitioners involved in development of medical necessity policy and approval of criteria?

- SCFHP does not produce internal criteria for medical necessity. The UMC approves MCG and the hierarchy of criteria annually.

3. Are they involved in Inter-rater Reliability testing for the physicians, and do they provide review sessions with the physicians on the IRR results?

- Dr. Boris, the UM Medical Director, does actively participate in the IRR process. Please see UMC Packet: BH IRR in Q1 2021 and Medical IRR Q3 2021.

Senior Level Practitioner

4. Do they provide input to the UM program development and the evaluation process?

- Dr. Lin, Dr. Boris, and Dr. Alkorashi all participate in the review and development of the UM program description annually.

5. Do they report to the board or the Chief Medical Officer (CMO) on UM activities and programs?

- All UMC meeting minutes are taken through the QI Committee to the Governing Board.
- The CMO, Dr. Laurie Nakahira, attends the UMC meetings. Dr. Nakahira also attends the Governing Board meetings.

Senior Level Practitioner

6. How involved are they with UM Delegates?

- Delegation issues that require UMC input are discussed on an as needed basis. Delegation oversight is structurally under compliance.
- Delegation is now a standing item on the Quarterly UMC meeting and is reviewed by UMC.

***As noted in 1-6 above, SCFHP has met the annual assessment of senior level practitioner (Medical and Behavioral health) in UM.

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Questions?

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Delegation Oversight

UM Delegates – UM Program Description

Delegate	Management Services Organization (MSO)	Version	Comments
North East Medical Services (NEMS)		2022	Title page date updated needed
Valley Health Plan (VHP)		2021	Pending 2022 version
Physicians Medical Group of San Jose	Excel MSO	2022	Reference to ICE to be updated to HICE (Health Industry Collaboration Effort)
Premier Care of Northern California	Conifer Value-Based Care	2022	Footer approval date update needed

NEMS UTILIZATION MANAGEMENT PROGRAM 2022

2021 Utilization Management Program
Table of Content

Appendix

Section I
Utilization Management Program

Policy

North East Medical Services (NEMS) operates a Utilization Management Program (UMP) as part of management services for members. The Program includes members enrolled in Medi-Cal Managed Care under contracted health plans.

Goal

The goal of the UMP is to assure delivery of medically necessary and optimally achievable quality patient care in a timely and cost-effective manner.

The UMP is designed to meet the requirements of contracted health plans and of accrediting and regulatory agencies including the California Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Health Care Finance Administration (HCFA), and Center for Medicare and Medi-Cal Services (CMS).

Scope

The program covers all members and patients assigned to NEMS through contracted health plans. Health plan members are assigned to the NEMS Clinic and other contracted Primary Care Providers (PCP).

Objectives

The UMP will ensure:

- Comprehensive planning, coordination and oversight to meet the client's overall health care needs
- Medically necessary services delivered at an appropriate level of care
- Matching authorized care and the benefits defined in the member's health plan
- At least annual evaluation of UM services for consistency with accepted standards of medical practice
- Ongoing evaluation of activities addressing over and under-utilization
- Application of standard and consistent criteria in utilization review decisions, including Medi-Cal Guidelines, Medicare Guidelines, MCG Guidelines, health plan's Policies & Procedures, and NEMS Policies & Procedures
- Both provider and client involvement in patient care plans for improved care and service
- Evaluation and consideration of new and existing technologies by the Utilization Management/ Quality Improvement Committee (UM/QI Committee)
- Review, evaluation, and improvement of outcomes by implementing new processes, revising existing processes, and maintaining the stability of those processes that are functioning well
- Annual review of UM performance and identification of barriers to expressed UM goals
- Annual Workplan toward removing identified barriers and enhancing UM outcomes

- Compliance with regulations for specific contracted member population (i.e., Medi-Cal, Medicare)
- Routine improvements to the UMP as necessary
- Annual evaluation and approval of the UMP, including UMP description, UMP Evaluation, UM Workplan, and Quarterly UM Reports by the UM/QI Committee and NEMS MSO Administration
- Updates on the UMP as needed if there have been organizational or structural changes within the MSO or new legislation that affect the UM process
- Annual submission of a written UMP description, UMP Evaluation, UM Workplan, and Quarterly UM Reports to all contracted Health Plans. Submissions may be more frequent as required by Health Plans.
- Monitor, evaluate and improve coordination of care among the medical and the behavioral health providers

Organizational Structure

The North East Medical Services (NEMS) Board of Directors is ultimately responsible for performance of utilization activities. The UM/QI Committee is established as a standing committee. The NEMS Board of Directors grants authority to the Chief Executive Officer (CEO) and President, the NEMS MSO Medical Director, and the UM/QI Committee to implement the UMP.

The UMP and QI Program manage resources, measure and evaluate cost, and assess health care delivery and clinical outcomes. Continuous quality improvement in clinical outcomes is achieved through effective integration of the two programs. The UM and QI functions are reviewed serially at each UM/QI Committee meeting, allowing a coordination of services between UM and QI. NEMS UM/QI Committee follows up on opportunities for improvement identified through the above assessment and evaluation activities, through corrective actions, their implementation, and follow-up reassessment.

UM Program Resources

Compensation:

The NEMS Chief Executive Officer (CEO)/President has the responsibility to allocate sufficient resources and staff for utilization activities.

NEMS employees and staff members are compensated for their services on a salary basis. Compensation for those who provide utilization review services does not contain incentives, direct or indirect, to influence them toward inappropriate review decisions or denials. The NEMS medical and nursing staff members serve as informational resources for the UM/QI Committee. NEMS personnel are professionally qualified to perform utilization review functions.

Oversight

The Board of Directors (BOD) delegates oversight for the UMP to the NEMS CEO and President. The NEMS CEO & President reports to the BOD on the status of the UMP at least quarterly. The NEMS CEO & President delegates routine, ongoing and continuous

responsibility for the UMP to the MSO Medical Director and to the UM/QI Committee. The UM Program is updated as necessary and evaluated for annual approval by the UM/QI Committee. Provisions adopted by the UM/QI Committee are binding on NEMS staff members, contracted physicians, and providers.

CEO and President

The NEMS CEO and President is appointed by and reports to the BOD. The CEO and President oversees the organization and management of the UMP, including financial viability, the allocation of resources, staffing, and interdepartmental effectiveness of the Program. The CEO and President acts as a resource to the UM/QI Committee and provides the Committee with administrative and financial data.

UM/QI Committee

The UM/QI Committee is delegated by, and accountable to the NEMS CEO and President. The UM/QI Committee oversees the development and implementation of an effective UMP through quarterly meetings, review of UM process, and oversight of UM focus studies with topics across the care continuum.

Responsibilities of UM/QI Committee

- Evaluate, develop, implement, and re-assess the UMP
- Monitor UM processes for improvement
- Coordinate the UMP with performance monitoring activities throughout the organization, including Quality Management, Credentialing, Member Services, and Medical Records
- Evaluate, develop, implement, and re-assess UM services to improve timeliness
- Evaluate, develop, adopt, implement, and re-assess UM criteria
- Investigate, resolve, and monitor daily operations relating to UM activities
- Monitor appropriate levels of healthcare
- Monitor patient services
- Monitor over and under-utilization of health care services
- Monitor misconducts related to payment or delivery of items or services
- Serve as educational liaison between the NEMS MSO and NEMS providers
- Oversee medical necessity of prospective, concurrent, and retrospective services for selected inpatient hospitalizations, emergency care, and outpatient services
- Assist the Quality Improvement (QI) team in reviewing problems--both actual and perceived--for potential quality issues (PQIs)
- Assist the QI team in developing, implementing, and re-assessing corrective action plans
- Provide final determination in case review processes
- Evaluate new and existing technologies
- Review and analyze pharmaceutical utilization data
- Review, discuss, and approve the UM quarterly reports and the annual UMP Evaluation
- Annually review, evaluate, and adopt the UMP, criteria, and workplan
- Review and approve NEMS UM Policies & Procedures at least annually
- Evaluate utilization review criteria at least annually

- Monitor compliance with federal, state, county, and other accrediting agencies' regulatory requirements
- Establish and maintain communication between physicians, providers, staff, facilities, clients, and other contracted entities
- Review and make determinations on all clinical appeals.

UM/QI Committee Chairman Responsibilities

- Presides over UM/QI Committee meetings
- Implements a formal process to providers notifying them of Committee recommendations and identified problems
- Notifies appropriate authorities of quality issues for which suspension or termination is recommended by the UM/QI Committee
- Designates a plan of action for concerns arising from Committee activities; delegates the person to carry out the action, and specifies the timeframe in which the action is to be performed
- Serves as interim decision-maker for urgent issues arising between scheduled UM meetings and reports them at the next scheduled UM/QI Committee when appropriate
- Provides monthly reports to the CEO/President

Term of Membership

The MSO Medical Director appoints physician members to serve on the Committee for one year, with renewable terms.

Composition

The UM/QI Committee reports to the NEMS CEO/President. The UM/QI Committee Chairman is the NEMS MSO Medical Director. The UM/QI Committee is composed of NEMS UM staff members and NEMS providers. The UM/QI Committee has four physician members representing primary care and specialty disciplines.

Members of the UM/QI Committee assist the committee with information and discussion of utilization issues:

1. UM Nurse and UM Coordinators (UMC) – Prepare monthly statistics on hospital and emergency room utilization. Provide information to the UM/QI Committee about the NEMS MSO authorization process. Report on authorization problems, denials, appeals, and utilization data.
2. NEMS MSO Medical Director reports on membership, utilization, guidelines, etc.
3. NEMS clinic providers who are designated as Physician Reviewers
4. Practitioner consultants from appropriate specialty areas of medicine and/or additional specialty sources and organizations are available to review cases pertaining to their specialty.
5. QI team members who may report QI projects, evaluation, work plans, complaints, and grievances, etc.

Voting Rights

Only practitioner (physicians and nurse practitioners) members may vote on medical issues.

Quorum

Two providers constitute a quorum for the transaction of Committee business. A majority of votes cast at a meeting, and at which a quorum is present, shall be required to take action. The members present at a meeting may continue to do business until adjournment, notwithstanding the withdrawal of sufficient members, leaving less than a quorum.

Health Plan Representative

Health plan representatives may attend UM/QI Committee meetings with prior arrangement through the MSO Clinical Operation Manager.

Meeting Schedule

UM/QI Committee meetings are held at least quarterly.

Subcommittees

An *ad hoc* UM subcommittee may be formed with a specific purpose and duration; there are no standing subcommittees.

UM/QI Committee Process

Minutes: Minutes will be maintained for each meeting using the NEMS MSO standard format. Minutes will reflect attendance and absences of each meeting, committee discussion, decisions made, actions taken and planned, responsible parties, implementation of actions, timeframe for completion of actions, and follow-up. When appropriate, documents discussed during Committee meetings are attached to the minutes.

Policies & Procedures: Written Policies & Procedures (P&P) used in the UM/QI process are distributed to and approved by the UM/QI Committee. Documentation includes a signature page with the date and reviewed/revised status noted. When written/revised, P&P are reviewed by Committee at the next scheduled UM/QI Committee meeting. Existing P&P are reviewed and approved at least annually by the UM/QI Committee.

Confidentiality: The Health Care Quality Improvement Act was enacted to provide a mechanism to improve the quality of medical care. The act provides immunity from liability for damages with respect to actions taken in the course of utilization review. Utilization activities are confidential and are not considered discoverable or admissible in a court of law. Additionally, peer review records and proceedings are kept confidential according to Section 1157 of the California Evidence Code. Proceedings and all documents of the UM/QI Committee are maintained in the strictest confidentiality. Members of the Committee will not discuss the proceedings or release documents of the Committee activities to any individual who is not a member of the Committee, except as it pertains to utilization case review proceedings, and to evaluate professional activities. Patient-approved communications

between NEMS MSO medical practitioners and any out of network providers are timely and confidential.

Intentional sharing, sale or use of medical information for any purpose not necessary to provide health care services to the member, except as otherwise authorized, is prohibited. Confidentiality statements are signed annually by all attendees of the UM/QI Committee. All UM/QI Committee correspondence and minutes are under the direct supervision of the NEMS UM/QI Committee Chairman and are maintained in a secure area.

Conflict of Interest: No one may participate in the review, evaluation, or final disposition of any case in which they have been professionally involved or where judgment may be compromised. If necessary, an outside board-certified physician reviewer will review the case to eliminate conflict of interest and to assure an objective determination.

No Incentives: NEMS MSO shall distribute an affirmative statement to its practitioners, providers, members, and employees and requires employees who make utilization-related decisions and those who supervise them to sign. The statement is to be signed and kept on file in the NEMS MSO UM Department. The statement contains the following:

1. UM decision making is based on appropriateness of care and service.
2. NEMS MSO does not compensate practitioners or individuals for denials.
3. NEMS MSO does not offer incentives to encourage denials.

Data Collection and Problem Identification: The Medical Information System is designed to provide monthly and cumulative reports for all patient services. Reports will be used for problem identification, performance evaluation, patient care outcomes, and client/staff education and training. Reports are available for carrying out quality and utilization management functions.

Data collection includes, but is not limited to:

- Adverse outcomes
- Bed days
- Complaints (member and provider)
- Emergency room usage
- Number of acute and SNF admissions/discharges
- Over-utilization
- Out-of-network referrals
- PCP to specialist referral patterns
- Retroactive authorizations
- Sentinel events
- Under-utilization

Data is derived from the entire NEMS MSO organizational operations: billing and claims, member encounters, health education, UM materials, medical records, physician office documentation, member/provider satisfaction surveys, and other miscellaneous sources. These data originate in all NEMS MSO clinical departments and cover the practices of both PCPs and specialists.

Data indicating potential **over or under-utilization** are reviewed by the MSO Director and MSO Medical Director. Interventions will be made (refer to the "Utilization Review for Over- or Under-Utilization" section in this manual.

Reports/results of clinical data/statistics: UM data/statistics are reported at least quarterly to the UM/QI Committee for review and recommendation.

Member and Provider Surveys: At intervals, and at least annually, NEMS MSO gathers information from members and practitioners soliciting feedback regarding satisfaction with the UM process, including satisfaction with obtaining services and referrals. Action and follow-up plans are created through the UM/QI Committee for approved member/provider-suggested changes and for identified sources of dissatisfaction. Results of action plans are re-evaluated within three months of implementation to evaluate improvements/changes, and to implement further action if necessary.

Annual UM Program Evaluation and Workplan

The UM/QI Committee reviews, evaluates, and approves the UM Program and Workplans. Annually in January, the UM Program, previous year's Workplan evaluation, and next year's Workplan will be reviewed by the UM/QI Committee. Quarterly, the UM/QI Committee reviews the updated Workplans. Workplans include objectives, scope of the year's activities, monitoring of previously identified issues, follow-up and tracking of issues over time, responsible parties, and projected completion times. The UM Program and Workplans are submitted to contracted health plans annually or more frequently as required by individual health plans.

Section II
Utilization Management Authorization Procedures

Treatment Authorization Requests (TARs)

The NEMS MSO will cover authorized services according to the specific terms of each physician, hospital, or other provider contract. The NEMS MSO will cover services only for individuals who are eligible health plan members and have selected a primary care provider in the NEMS MSO network at the time the service is rendered.

Certain procedures, services, and medications require prior authorization from the NEMS MSO before reimbursement can be made. Providers must use the Treatment Authorization Request (TAR) to request approval directly from the NEMS MSO UM Department for these procedures and services. All inpatient admissions, outpatient surgeries, and other non-physician services (e.g., home health, non-emergency ambulance transport) require prior authorization (TAR). A listing of procedures requiring or not requiring TAR is posted on the NEMS MSO website at https://www.nemsmso.org/

TAR may be filled out and submitted by the PCP or specialist who will perform the service. TAR may be faxed to NEMS MSO or submitted via the provider portal.

All TARs will initially be reviewed by the UMC in the NEMS MSO UM Department. The UMC may provide an authorization if the member is eligible, the service is a covered benefit, and the medical criteria are met. If the UMC is unable to approve the service, the TAR will be forwarded to the UM Nurse or physician reviewer for review.

NEMS MSO makes available to physicians a physician reviewer in person or by phone to discuss determinations based on medical appropriateness.

PCPs shall refer members to NEMS MSO participating physicians unless necessary specialty services are unavailable in the NEMS MSO network. Out of network specialty referrals by the PCP are subject to approval per UM Department procedure.

UM Team and Responsibilities

The UM team consists of physicians, nurses, and coordinators. NEMS MSO uses licensed health care professionals (physicians and nurses) to supervise UM activities and to make UM decisions that require clinical judgment. Responsibilities of the UM team members are outlined as follows:

1. Chief Strategy Officer

The Chief Strategy Officer (CSO) is a Board-certified physician who holds a current unrestricted license to practice in the State of California and is credentialed by the NEMS MSO. The CSO oversees the MSO Medical Director and the UM operations. The CSO is available to UM staff on site or by telephone. The CSO is also a Physician Reviewer who reviews Treatment Authorization Requests (TARs) that are referred by the UMC and nurses

for review. The CSO reports the overall UM department operation and performance to the CEO.

2. MSO Medical Director

The NEMS MSO Medical Director is a Board-certified physician and holds a current unrestricted license to practice in the State of California and is credentialed by the NEMS MSO. The MSO Medical Director is appointed by and reports to the CSO. The MSO Medical Director is responsible for appropriate development and implementation of the UMP, policies and procedures, UM criteria, and identifying under- and over-utilization. The MSO Medical Director serves as Chairman of the UM/QI Committee. The MSO Medical Director is also a Physician Reviewer who reviews TARs that are referred by the UMCs and UM Nurses.

3. Physician Reviewers

Physician Reviewers are Board-certified physicians who hold a current unrestricted license to practice in the State of California and are credentialed by the NEMS MSO. The Physician Reviewer team includes the CSO, MSO Medical Director, and two physicians who are practicing at the NEMS clinic and designated by the CSO as Physician Reviewers. Physician Reviewers review TARs that are referred by the UMCs and UM Nurses. Physician Reviewers review relevant clinical information and consults with the treating provider as needed.

Physician Reviewers make UM decisions that require clinical judgment. Physician Reviewers may deny TARs that do not meet UM criteria. They may consult with a specialist in the same specialty as the rendering provider or refer the case to an external reviewer in the same specialty. Only physicians with appropriate clinical expertise in treating the medical or behavioral health condition can make a decision to deny or authorize an amount, duration, or scope that is less than requested on the basis of medical necessity. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification. All denial decisions, whole or in part, are made by a qualified physician regardless of whether the denial is due to no medical necessity or not a covered benefit.

The following cases require physician review:

- Organ transplant
- Genetic testing
- Gender-affirming services
- Investigational services
- Medical necessity guidelines not met
- Non-covered benefit
- Out-of-network requests with no continuity of care needs
- Complex cases that may need physician’s input
- New medical technology

4. MSO Clinical Operation Manager

NEMS MSO uses licensed health care professionals to supervise UM activities. The MSO Clinical Operation Manager (MSO COM) is a UM Nurse who holds a current unrestricted Nurse Practitioner/Registered Nurse license to practice in the State of California. The MSO

COM oversees the UMCs and supervises UM activities. The MSO COM's responsibilities include but are not limited to the following areas:

- Provide day-to-day supervision of assigned UM staff
- Participate in staff training
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Monitor documentation for adequacy
- Is available to UM staff on site or by telephone
- Assist the MSO Medical Director in effective clinical coordination and integration of the UMP
- Revise the UM program, policies and procedures based on Health Plan, NCQA, Federal and State requirements. The revised programs, policies and procedures, and UM performance reports are presented to the UM/QI Committee for review and approval.
- Ensure that UM reports that are required by health plans, such as UM Work Plans, are presented to the UM/QI Committee quarterly and annually for review and approval.
- Ensure that the required reports are submitted to the Health Plans in a timely manner.

The MSO COM reviews complex cases that are referred by the UMC. The MSO COM provides instructions to UMCs on whether the case should be approved or referred to the Physician Reviewer. The MSO COM makes decisions that require clinical judgment and can only make approval decisions. Cases that are potential denials are referred to Physician Reviewers for review. Example of cases that the UM Nurse may approve:

- Chemotherapy drug approved by the Food and Drug Administration for the diagnosis
- Radiation
- Non-emergency medical transportation
- Out-of-network requests for continuity of care
- Skilled nursing/ Long Term Care/ Subacute care
- Services that meet UM criteria
- Infusion
- Hospice
- Genetic testing that meets UM criteria
- PT/OT/ST

5. UM Coordinator (UMC)

The UMCs are not licensed, qualified health care professionals. They are under the supervision of the MSO COM who is a licensed health professional. The UMCs can approve services when there are explicit UM criteria and no clinical judgment is required.

The UMC reviews and approves TARs if the TAR meets the following criteria:

- Member is eligible
- Requested service is a covered benefit
- Rendering provider is in-network
- Services meet medical necessity criteria that are explicitly stated in Medi-Cal, Health Plan, and MCG criteria and no clinical judgment is required

The UMC refers the following complex cases to the UM Nurse or Physician Reviewers for review:

- Genetic testing
- Chemotherapy
- Radiation
- Infusion
- Hospice
- PT/OT/ST
- Out-of-network requests
- Non-covered benefits
- Does not meet medical necessity criteria from Medi-Cal, Health Plan, and MCG
- Gender-affirming services
- Organ Transplant
- Transportation
- Investigational services
- Surgeries

Requesting providers may submit a TAR via the NEMS MSO Provider Portal or via fax to the UM Department. The incoming fax system automatically applies a date and time stamp on the bottom of the fax. The UMC performs the following duties:

1) Review member eligibility – Prior to providing services, it is the responsibility of the PCP, hospital, or other health care provider to verify eligibility of the member at the time the service is provided. Providers are responsible for checking patient eligibility prior to rendering services by verifying eligibility directly with the member's health plan. The MSO UMC verifies eligibility when a TAR is received. The requesting providers and members will be notified if the member is not enrolled with NEMS.
2) Review benefit coverage
3) Gather UM guidelines – Medi-Cal, Health Plan, MCG guidelines
4) Approve TAR if eligibility and UM criteria are met
5) Refer complex cases to UM Nurse or MSO Medical Director/Physician Reviewer
6) Follow-up recommendations from the UM Nurse and MSO Medical Director/Physician Reviewer
7) Document in EZCAP

Staffing Ratio and Cross Training

The UM team consists of physician and non-physician staff. The physician staff are the physician reviewers who are medical doctors. The physician reviewer team consists of one Chief Strategy Officer, one MSO Medical Director, and two practicing physicians from the NEMS clinics. The non-physician staff consists of one UM Nurse and six UMCs. The UM Nurse is currently a Nurse Practitioner holding the title of MSO Clinical Operation Manager.

Some UMCs are Medical Assistants who received Medical Assisting training.
One UMC is responsible for a maximum of 10,000 members. Depending on the workload and department needs, the staffing may increase to ensure UM duties are performed and completed

in a timely manner. The UMCs present cases to the UM Nurse for advice or directly to the physician reviewer if the UM Nurse is not available.

The MSO Clinical Operation Manager has the overall responsibility of training the UMCs and may assign some of the training duties to the senior UMCs. UMCs are cross trained to perform various UM duties, such as completing inpatient and outpatient TARs, CCS referrals and follow-up, TARs for different networks, and submission of UM reports to Health Plans, etc. The goal is to have one primary person responsible for the task and at least one back-up person to perform the task as needed.

The Chief Strategy Officer has the overall responsibility of training the physician reviewers. The physician reviewers are trained on UM criteria, UM process, and can cover for each other when one is not available.

Training of the UM team is done on an ongoing basis when UM policies and procedures are changed or when information needs to be reinforced. When new changes are made to the UM policies and procedures, the MSO Clinical Operation Manager trains the UM team on the changes. The UM team meets daily to discuss UM cases and UM processes. At least one physician reviewer is available every day for case review. If the UM Nurse is not available, the UMC presents the cases to the physician reviewer. The physician reviewers are trained on the UM Nurse's duties and can provide guidance to the UMCs.

Another training opportunity is the review of a Health plan's appeal cases in the quarterly UM/QI Committee Meeting where physician reviewers, UM Nurse, and UMCs discuss the appeal decisions, guidelines used for denial, appropriateness of the denial, and any changes to the UM process, as needed. In addition, the interrater reliability study results are discussed in the UM/QI Committee Meeting. Deficiencies and corrective actions are discussed to ensure that the UM process is followed.

Procedures Not Requiring Prior Authorization

Prior authorization for the following procedures is not required. The list is posted on the website https://www.nemsmso.org.

1. **Sensitive Services** – Medi-Cal members may self-refer to any providers for pregnancy testing, family planning services, HIV testing, abortion services, and treatments of sexually transmitted diseases
2. **Abortion Services** – Outpatient services do not require prior authorization, unless hospitalization is needed
3. **EPSDT/CHDP services** provided by PCP, FQHC, community clinic, DPH per EPSDT/CHDP periodicity schedules and guidelines
4. **OB/GYN Services** – A member may self-direct to in-network providers for obstetrical and gynecological services
5. **Tuberculosis Care** – Tuberculosis screening, testing, and treatment, do not require prior authorization, unless hospitalization is needed
6. **Well Woman Care** – Services provided according to ACOG guidelines with emphasis on preventive screening, including routine Pap smear, breast exam, and mammography, do not require prior approval

7. **Hospice Care (Outpatient)** - Authorization is not required for routine home care, continuous home care, respite care, custodial care, or for hospice physician services
8. **Preventive Care Screening –** Screening colonoscopy/sigmoidoscopy, cervical cancer screening, breast cancer screening
9. **Biomarker Testing (effective 7/1/2022)** – Authorization is not required for members with advanced or metastatic stage 3 or 4 cancer for FDA-approved therapy
10. **Non-Medical Transportation** – Contact member's health plan

Procedures Requiring Prior Authorization

Prior authorization for the following procedures is required. The list is posted on the website https://www.nemsmso.org.

1. Acupuncture
2. Allergy injections
3. Ambulatory Surgery Services
4. Audiological Services
5. Bone Density Studies
6. Chemical Dependency Services
7. Chemotherapy
8. Chiropractic
9. Colonoscopy/ Sigmoidoscopy (diagnostic)
10. CT Scans / MRI/ PET Scans
11. Cardiac Non-invasive Test
12. Custodial Care
13. Durable Medical Equipment (DME)
14. Elective Sterilization
15. Electric Breast Pump (hospital grade)
16. Experimental/ Investigational Treatment
17. Gamma Immune Therapy
18. Gender Reassignment
19. Genetic Testing
20. Hearing Aids
21. Home Health Care/ Home Infusions Services
22. Hospice Care for General Inpatient Level of Care
23. Hospital Admission
24. Laboratory Procedures Costing Over $300
25. Non-Emergency Medical Transportation
26. Nuclear Medicine Studies
27. Obstetric Procedures (include amniocentesis/ more than 1 ultrasound)
28. Office Procedures costing over $300
29. Outpatient Hospital Procedures (including imaging and other ancillary services done in the outpatient hospital setting)
30. Renal Dialysis
31. Sleep Studies
32. Specialist to Specialist Referrals
33. Skilled Nursing and Intermediate Care
34. Surgeries

35. Therapy Services (include PT, OT, Speech)
36. Transplant

Medical Necessity

The Medi-Cal program defines medical necessity as the provision of health care services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Authorization may be granted when the services requested are reasonably expected to:

- Restore lost functions
- Minimize deterioration of existing functions
- Provide necessary training in the use of orthotic or prosthetic devices
- Provide the capability for self-care, including feeding, toilet activities and ambulation

Authorization may be granted when failure to achieve the goals listed above would result in the loss of life or result in significant disability.

UM Criteria

UM criteria are used to assist UM staff in determining the benefit coverage and medical necessity of requested services. NEMS MSO does not create UM criteria. Instead, NEMS reviews and adopts criteria that are based on sound medical evidence and are regularly reviewed and updated. Annually, the UM/QI Committee reviews and approves written criteria to ensure the criteria are consistent with acceptable standards. The UM/QI Committee consists of physician members from Family Practice and Pediatrics and will invite other specialists as appropriate should the need arise.

The clinical criteria are applied in the hierarchy as listed below:

1. Federal/State mandates (Medi-Cal/CMS) criteria

2. State law - When state requirements trump or exceed federal requirements, NEMS follows the state law that is more stringent and extensive.

3. Health plan adopted Guidelines (San Francisco Health Plan, Santa Clara Family Health Plan, Anthem Blue Cross adopted the AIM Radiology Guidelines, Anthem Medical Policy, and Anthem UM Clinical Guidelines)

4. MCG Health and other evidence-based guidelines

5. External reviewer – The NEMS MSO physician reviewer reviews the evidence in consultation with relevant external, independent specialty expertise when there are no available criteria.

UM Criteria are available to members and providers upon request to the NEMS UM staff. Requests can be made by phone, fax, in writing, or email. UM staff mails the criteria to providers who do not have fax or email.

Clinical practice guidelines are reviewed by the UM/QI Committee and distributed to primary care and specialty providers via the NEMS Provider Newsletter and/or NEMS MSO website.

Providers and other staff who make utilization decisions are informed of the need for special attention to the risks of underutilization. Clinical criteria for determining medical appropriateness are applied for each case individually based on specific case considerations such as age, co-morbidities, complication, progress of treatment, family/social support systems, home environment, and psychosocial situation. The local delivery system, e.g., availability of skilled nursing facilities and ability of local hospitals to provide the care will also be taken into consideration.

Cases in which medical necessity is not addressed by standard guidelines, but are denied for lack of medical necessity, should be reviewed and denied by a physician reviewer in the same specialty. When a physician reviewer in the same specialty is not available internally, the UM staff sends the case to an external reviewer for review. Reports from the external reviewer will be reviewed by a Physician Reviewer for a decision that is based on the individual member's medical needs.

Board-certified Specialty Review

NEMS MSO uses Board-certified physicians from appropriate specialties to assist in making determinations of medical appropriateness when there are no available appropriate criteria. The practitioners who make UM decisions hold current medical licenses to practice without restriction. The NEMS MSO Medical Director consults with appropriate specialists on the following list.

Board Certified Specialty	**Consultant Name**
Cardiology	Hong Zheng, D.O.
Gastroenterology	Dennis Shen, M.D.
General Surgery	Philip Chung, M.D.
Hepatology	Chanda Ho, M.D.
Neurology	Jason Lin, M.D.
Obstetrics/Gynecology	Rena Hu, M.D.
Obstetrics/Gynecology	Jonathan Wong, M.D.
Obstetrics/Gynecology	Esther Chang, M.D.
Ophthalmology	Danny Lin, M.D.
Ophthalmology	Ali Zaidi, M.D.
Ophthalmology	Emily Charlson, M.D., Ph.D.
Endocrinology	Karen Chang, M.D.
Otolaryngology	Kevin Ho, M.D.
Podiatry	Gary Lam, M.D.
Plastic and Hand Surgery	Hubert Shih, M.D.

If the case requires a specialty that is not locally available, the case will be referred to Advanced Medical Reviews (AMR) for medical review. AMR is an independent medical review agency with Board certified physicians in a wide range of specialties. AMR is accredited by Utilization Review Accreditation Commission (URAC) to provide utilization management review.

The UM team consistently applies UM criteria for review and approval, modification, delay or denial of services. Interrater Reliability Studies are performed on physician and non-physician reviewers annually to ensure UM criteria are consistently applied (Refer to Interrater Reliability section in this manual). The MSO Medical Director contacts health plans and MCG if UM criteria need to be updated. Updated UM criteria will be presented to the UM/QI Committee for review and approval.

UM Documentation

The UM team clearly documents reasons for UM decisions in the UM EZCAP system. Documentation should be written in clear and concise language:

1. Stating the facts and is objective
2. Completed on time in chronological order
3. May have "quotes" that are direct language from the caller when appropriate
4. Document name and title of the person who made the UM decision
5. The reason for the UM decision, e.g., decision supported by UM criteria and health plan's member benefit handbook
6. If denial, state the reason not meeting UM criteria
7. Keep TAR, eligibility screen, progress notes, UM criteria, denial letter, and other pertinent information in patient's file
8. Refer to section on "Communication about Denial or Modification" in this manual for denial letter documentation

Collection of relevant clinical information

When making a determination of coverage based on medical necessity, the UM team obtains information reasonably necessary to make a decision and consults with the requesting/ treating provider for medical services, when appropriate. The data and information the UM team uses to make determination includes the following items:

1. Member eligibility
2. Evidence of Coverage
3. Network services that are available
4. Member's medical records
5. Conversations with requesting/treating providers
6. Conversations with member and family
7. Medical criteria
8. Precedent-Setting Cases

Disclosure of policies, procedures, and criteria

Providers are informed how to obtain criteria during NEMS provider orientation. NEMS MSO may disclose UM policies, procedures, and criteria used to authorize, modify, or deny healthcare services to contracted healthcare providers, members, and member designated representatives. The UMC may receive requests for release of policies, procedures, and criteria by phone, fax, email, or mail. The UMC presents the case file to the UM Manager or MSO Medical Director/Physician Reviewer for review to ensure that the pertinent policies, procedures and criteria are selected. The UMC will provide paper copies of the information to

the requesting provider, member or member designated representatives using the following methods:

- Copy criteria for each provider
- Read over the phone
- Make available for review at NEMS MSO office
- Distribute via email

Providers are informed of the following policies via the NEMS Medical Group Provider Manual:

- UM policies, procedures, and criteria used to authorize, modify, or deny healthcare services are available upon request
- An appropriate physician reviewer is available to discuss any UM denial decision by contacting the NEMS MSO
- Standing Specialist Referral policy

Authorizations After Office Hours

The NEMS MSO Medical Director is responsible for final approval of all services requiring prior authorization. In the absence of the MSO Medical Director, the authorization process is as follows:

- The Physician Reviewer will review the TAR and determine the UM decision.
- Urgent authorizations are decided within 72 hours of receipt of the request.
- If an emergent situation arises after business hours, the PCP or on-call physician may instruct the patient to go to the nearest emergency room. Prior authorization is not required for emergency services.
- If contracted providers are not available for any health condition of a member, referrals to non-contracted providers may be made.
- Requesting providers can also leave a message at the NEMS UM voicemail and messages will be returned within one business day.

Timeliness of UM Decisions

NEMS MSO follows the Department of Health Care Services (DHCS) Timeliness Standards for Utilization Management. NEMS MSO makes UM decisions in a timely manner to accommodate the clinical urgency of the situation. Urgent care is when a delay of care could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without care or treatment. Requests for pain medication or treatment for the terminally ill will be treated as an urgent request and follow all the turnaround time requirements for urgent requests, including UM decisions, verbal, and written communication.

1. For urgent concurrent requests, NEMS MSO makes decisions within 72 hours of receipt of the request.

2. For urgent preservice requests, NEMS MSO makes decisions within 72 hours of receipt of the request.
3. For non-urgent preservice requests, NEMS MSO makes decisions within 5 business days of receipt of the request.
4. For post-service requests (retro), NEMS MSO makes decisions within 30 calendar days of receipt of the request.
5. An extension of 14 calendar days may be granted if either the member or provider requests the extension, or NEMS MSO justifies a need for additional information and how the extension is in the member's best interest.

Timeliness of UM Decisions Notification

NEMS MSO notifies providers and members in a timely manner to accommodate the clinical urgency of the situation:

1. For urgent concurrent decisions, NEMS MSO notifies the requesting provider initially by telephone, fax or email and then in writing within 24 hours of making the decision but not to exceed 72 hours from time of receipt. NEMS notifies member in writing within 24 hours from the decision but not to exceed 72 hours from time of receipt.
2. For urgent preservice decisions, NEMS MSO notifies the requesting provider initially by telephone, fax or email and then in writing within 24 hours of making the decision but not to exceed 72 hours from time of receipt. NEMS MSO notifies the member in writing within 24 hours from the decision but not to exceed 72 hours from time of receipt.
3. For non-urgent preservice decisions, NEMS MSO notifies the requesting provider initially by telephone, fax or email and then in writing within 24 hours of making the decision. NEMS MSO notifies the member in writing within 2 business days from the decision but not to exceed 15 calendar days from time of receipt.
4. For non-urgent preservice decisions, an extension of 14 calendar days may be granted if either the member or provider requests the extension, or the NEMS MSO physician reviewer justifies a need for additional information. The decision to pend should be made by a NEMS physician reviewer by the fifth business day from time of receipt. The case will be pended for 14 calendar days from time of receipt. NEMS MSO notifies the requesting provider initially by telephone, fax or email and then in writing within 24 hours of making the decision to pend. NEMS MSO notifies the member in writing within 2 business days from the decision to pend. The "pend" letter for member and provider will include the medical reason to pend and the expected decision date (not to exceed 14 calendar days from day of receipt). If medical information is still missing by the 14th calendar day from the day of receipt, a denial will be issued. NEMS MSO notifies the requesting provider initially by telephone, fax or email and then in writing within 24 hours of making the decision. NEMS MSO notifies the member in writing within 2 business days from the decision (refer to the policy on Pended Request and Notification in this manual).
5. For post-service decisions (retro), NEMS MSO notifies the requesting provider initially by telephone, fax or email and then in writing within 24 hours of making the decision but not to exceed 30 calendar days from time of receipt. NEMS MSO notifies members in writing within 2 business days from the decision but not to exceed 30 calendar days from time of receipt.
6. For all covered outpatient drug prior authorization requests, the UM team provides notice by telephone, fax, email or other electronic communication within 24 hours of receipt of

the request, and in emergency situations authorize at least a 72-hour supply of the covered outpatient drug, in accordance with Welfare and Institutions Code Section 14185(a)(1), 42 CFR 438.3(s)(6), and Section 1927(d)(5)(A) of the Social Security Act.

7. In situations where a UM decision is made on the due date that a verbal notification turnaround time has to be met before a long weekend, the UM staff notifies the member and provider of the decision by phone or fax on the same day of the decision prior to the long weekend.
8. In situations where a UM decision is made on the due date that a letter is due or the turnaround time has to be met before a long weekend, the UM staff notifies the System Configuration team on the same day of decision to generate the letter, attach the letter to EZCAP, and record the date of the letters mailed. UM mails the letter on the same day of UM decision.

Medi-Cal Turnaround Time Grid

	Receipt	Decision	Decision if Pend	Member Notification of Final Decision	Provider Notification of Final Decision
Routine	Day 0	Within 5 business days from Day 0	Up to 14 calendar days from Day 0	In writing within 2 business days from the decision, but not to exceed 14 calendar days from Day 0	In writing within 24 hours from the decision, but not to exceed 14 calendar days from Day 0
Urgent	Day 0	72 hours from Day 0	72 hours from Day 0	In writing within 24 hours from the decision, but not to exceed 72 hours from Day 0	In writing within 24 hours from the decision, but not to exceed 72 hours from Day 0
Concurrent (inpatient)	Day 0	72 hours from Day 0	72 hours from Day 0	In writing within 24 hours from the decision, but not to exceed 72 hours from Day 0 (excluding approvals)	In writing within 24 hours from the decision, but not to exceed 72 hours from Day 0
Retrospective	Day 0	30 calendar days from Day 0	N/A	In writing within 30 calendar days from Day 0	In writing within 30 calendar days from Day 0
Pharmaceutical	Day 0	24 hours from Day 0	24 hours from Day 0	In writing within 24 hours from Day 0	In writing within 24 hours from Day 0

Communication Services

NEMS MSO educates providers about the UM processes on an ongoing basis. Education may include the following items:

- UM Affirmative Statement and UM Staff Availability information is posted on the NEMS MSO Portal at https://www.nemsmso.org/um-functions/ which is available for members, providers, and the public to access
- UM Affirmative Statement and UM Staff Availability information is also posted on the NEMS provider portal where providers submit treatment authorization requests on-line
- Prior authorization procedures and timeframes are written in the NEMS MSO Provider Newsletter

1. Utilization Management (UM) Affirmative Statement

Decision to approve or deny a service is based only on appropriateness of care, service, and existence of coverage. NEMS does not reward providers or other individuals for issuing denials of coverage or service care. There are no financial incentives for decision makers that would result in underutilization. The cost of the requested service is not a factor the UM takes into consideration during its decision-making process. Members and providers may request a copy of the policies, procedures, and criteria used to make a determination for a specific procedure or condition by contacting NEMS UM at 1(415) 352-5186, option 1.

2. UM Staff Availability

NEMS UM staff are available to members and providers during regular business hours (Monday through Friday, 8:00am - 5:30pm) to discuss UM issues, including denial decisions, and to request a copy of the policies, procedures and UM criteria, by calling 1 (415) 352-5186, option 1. TTY services 1 (800) 735-2929 is available for the hearing impaired. For all members who request language services, NEMS provides language assistance, free of charge, in the requested language through bilingual staff or an interpreter. NEMS UM staff can receive secure voicemail, fax, and email for after-hours communication. The NEMS UM fax number is 1 (415) 398-2895. Members and providers can also email us at MSO-UM@nems.org for any UM questions. Messages received are returned within one business day. NEMS UM staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.

Communication of UM Decisions

1) Communication about Approval

When a TAR is approved, the specific health care service approved is stated on the approval letter. Approval letters are available in the provider portal for download. In addition, approval letters are automatically generated the next day at 7:00 am to be mailed out by the UMCs the same day.

2) Communication about Denial or Modification

Only a physician reviewer can deny or modify a TAR, regardless of whether it is a benefit denial or a medical necessity denial. After a physician reviewer denies or modifies a TAR, the UMC prepares the Notice of Action (NOA) letter for the physician reviewer to approve. NOA letters are generated for all denials and modifications within the required turnaround timeframe as outlined in the above Medi-Cal Turnaround Time Grid for urgent, routine, concurrent and retrospective requests. NOA letters will be faxed and/or mailed to the requesting provider and member.

NOA letters are generated using the Health Plan's templates. The following elements must be included in the NOA letters:

- Correct member and Health Plan information
- Correct Health Plan template, logos, and disclaimers
- Clear and concise explanation of the reasons for the UM decision
- Clinical reasons for the decision
- Language of the denial explanation must be understandable to the layperson with a sixth-grade education
- Description of the criteria or guidelines used for the decision, including the product name of the criteria, policy/procedure or guideline and title of the specific criteria used to make the decision
- A reference to the benefit provision, guideline, protocol or other criteria on which the denial decision is based. It includes specific reference to the criteria. The criterion referenced must be identifiable by name and must be specific to an organization or source
- A member, member representative and provider may ask for free copies of all information used to make the decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria
- Information about alternative care if appropriate
- Provider may speak directly with the NEMS MSO physician reviewer who made the decision
- Name and direct telephone number of the physician reviewer who is responsible for the denial
- Physician reviewer's signature
- DHCS "Your Rights" document
    - How to file a standard or expedited appeal
    - State Hearing Form
- How to request an independent medical review (IMR)
    - IMR Form and envelope addressed to DMHC to be included for adverse decisions of certain services such as investigational therapy, urgent care, and emergency services.
- Non-Discrimination Notice and taglines with language assistance information - the taglines inform members of the availability of language assistance services
- NOA letter, in its entirety, is provided in member's preferred language using Health Plan's NOA letter template available in Health Plan's threshold languages.

References:

1. **DHCS APL 21-011:** Grievance and Appeal Requirements, Notice and "Your Rights" Templates

2. **DHCS APL 21-004:** Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistant Services

3) Communication about Pending Status

When a UM decision cannot be made within 5 business days from the receipt date, the UM team sends a letter to the member and provider to explain the decision to pend the case. The guidelines for communicating to the member and provider is listed in the "Pended Request and Notification" policy in this manual.

4) "Confidential" envelope

The UMC stamps the envelope "confidential" and seals the envelope before mailing the approval and NOA letters.

Out-of-Network Services

When a member's health care needs are not met by providers in the NEMS MSO network, NEMS MSO may authorize services out-of-network. The UMC will assist members in locating an appropriate out-of-network provider and coordinating care as needed. NEMS MSO Provider Relations will set up a payment agreement with the out-of-network provider. Covered services that are provided by out-of-network providers and prior authorized by NEMS MSO are at no cost to Medi-Cal members.

UM Quality Auditing Process

NEMS has an ongoing monitoring process in place to audit UM activities. The Quality Improvement (QI) team is responsible for auditing the UM process since the QI team is not involved in the day-to-day UM operation and is objective in the review process. Results and findings are discussed in the quarterly UM/QI Committee Meetings. The following are audits performed by the QI team:

1) Quarterly review of the UM process

The QI team audits the UM process quarterly. The QI team works with the MSO Clinical Operation Manager to identify the UM process that needs to be audited. The areas being audited may include new UM processes, deficiencies identified during Health Plan audits, and other review opportunities identified. Results and findings of the QI team will be presented to the UM/QI Committee for discussion and recommendation.

2) Interrater Reliability Review (IRR)

NEMS evaluates annually the consistency with which the physicians and non-physician reviewers (UM Nurse and UMCs) involved in utilization review apply the criteria used in decision-making. A random selection of charts are reviewed annually (see Appendix 1 and 2 for the IRR Audit Tools). The QI team uses the 8/30 methodology for sample size for each UM

team member. If all 8 denial files scored 100%, no additional files will be reviewed. If any deficiencies are found in the 8 files, a total of 30 files for the UM team member will be reviewed. A passing score is 90% or higher. The results of the IRR are reviewed by the UM/QI Committee. The physicians and non-physician reviewers will be notified of the results and the UM/QI Committee's recommendation.

Quarterly, the QI team will review the UMCs' turnaround time in completing an authorization request. The Medi-Cal Turnaround Time Standards are followed. The QI team uses the 8/30 methodology for sample size for each UMC for the timeliness of decision-making and notifications (oral or written) to members and providers. A passing score is 90% or higher.

The MSO Clinical Operation Manager will discuss the results of the IRR studies with individual UMCs. Any scores below 90% will require a corrective action plan to be generated by the MSO Clinical Operation Manager and the UMC. The MSO Clinical Operation Manager will provide appropriate training and guidance to the staff member.

The QI team will perform a re-review three months after initiating the corrective action plan with the UMC. The QI team will use random selection and the 8/30 methodology again for sample size. If the UMC continues to receive a score below 90% during the re-review, the UMC will be placed on probational status. The MSO Clinical Operation Manager will work with NEMS Human Resources on the probational status and corrective actions.

If a physician reviewer receives a score below 90% in the IRR studies, the Chief Strategy Officer or the MSO Medical Director will discuss the results with the physician reviewer, formulate a corrective action plan, and provide appropriate training to the physician reviewer.

The QI team will perform a re-review three months after initiating the corrective action plan with the physician reviewer. The QI team will use random selection and the 8/30 methodology again for sample size. The physician reviewer who continues to receive a score below 90% in the re-review will be excluded from the physician reviewer duties. The Chief Strategy Officer or the MSO Medical Director will select another physician to perform the reviewer duties.

Discharge Planning

Discharge planning begins with the decision to hospitalize a client. It is a process by which health care professional, patients, and families collaborate to ensure continuity of care for identified patients. To help patients maintain and improve health status post-hospitalization, patients and their families are educated and trained in care, available and appropriate non-acute facilities, home care, and community resources. NEMS treating physicians, UM Nurses, and other departmental staff perform in discharge planning capacities.

UM Appeal Policy (applies if not delegated for appeals)

Members and/or providers can appeal denials of services through the health plan when NEMS MSO is not delegated for the appeal. A member has the right to file a formal complaint, grievance, and appeal directly with the health plan or to request a Fair Hearing with the Department of Health Services. The member is instructed to call the health plan to initiate this process, or to call the NEMS MSO Member Services Department for assistance.

If NEMS MSO is not delegated for appeals and grievances, NEMS MSO forwards appeals and grievances to the health plan upon receipt.

Denials, modifications, and deferrals are tracked daily to make sure that follow-up items are being followed:

1. Inform providers about denials, modifications and deferrals by phone and letters following the turnaround timeline stated in the UM Program
2. Follow up with provider and patients by phone as needed, e.g., call patient and provider to redirect service to in-network providers
3. Coordinators track deferrals to ensure the proper turnaround time
4. Members are directed to alternative care if services are denied

Standard Appeal (applies if delegated for appeals)

If NEMS MSO is delegated for appeals and grievances, NEMS MSO follows the appeal procedures.

An appeal is the process by which a member appeals a decision regarding a denied or deferred referral for health care services. Member Services Representatives can assist members in filing an appeal. The NEMS MSO Medical Director will be immediately informed of all urgent and emergent appeals.

A member can file an appeal orally or in writing. The member and/or a clinical provider acting on behalf of a member may initiate an appeal. Once the appeal is received by NEMS MSO, the Appeal Coordinator will log and investigate the issue. The member will be sent a letter acknowledging the appeal within 5 days of receipt.

The Appeal Coordinator will investigate the appeal including any aspects of clinical care involved. NEMS MSO appoints a person to review the first level appeal who was not involved in the initial determination. The person appointed to review an appeal involving clinical issues is an actively practicing provider in the same or similar specialty who typically treats the medical condition.

Within 30 days, the member will be informed in writing of the resolution of the appeal. Written notification to the member will include the disposition of the appeal and the right to appeal further. If NEMS MSO cannot make a decision within 30 working days due to circumstances beyond its control, NEMS MSO will issue a written decision within 15 additional working days and provide notice to the member with the reasons for the delay before the 30th working day.

Expedited Appeal (applies if delegated for appeals)

For all urgent, routine, and concurrent review authorization requests resulting in a denial, both member and provider denial notification includes a description of the process for initiating an expedited appeal. The member and/or provider acting on behalf of a member may initiate an expedited appeal. The appeal can be filed orally or in writing.

Once the appeal is received by NEMS MSO, the Appeal Coordinator will log and investigate the issue. The Appeal Coordinator will investigate the appeal including any aspects of clinical care involved. NEMS MSO appoints a person to review the first level appeal who was not involved in the initial determination. The person appointed to review an appeal involving clinical issues is an actively practicing provider in the same or similar specialty who typically treats the medical condition.

Notification of an expedited appeal decision is made as soon as the medical condition requires, but no longer than 72 hours after the request is made. If initial notification of the expedited appeal decision was not in writing, NEMS MSO provides written confirmation of its decisions within two (2) working days of providing initial notification. Written notification to the member will include the disposition of the appeal and the right to appeal further. This expedited appeal policy applies to all NEMS MSO departments and products.

Maternity Benefits

The time frames for maternity benefits for inpatient hospital care is 48 hours following a normal vaginal delivery and 96 hours following a delivery by C-section. Length of stay is calculated beginning with the time of delivery. The decision to discharge the mother and her newborn before the mandated timeframes is made by the treating physicians in consultation with the mother.
Coverage is provided for a post-discharge visit for the mother and her newborn within 48 hours of discharge if the mother and newborn are discharged in less than 48 hours following a normal vaginal delivery and less than 96 hours following a C-section. The visit includes parent education, assistance and training in breast feeding or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments.

Disease Management Programs

Disease management programs at NEMS MSO are prohibited from soliciting or offering for sale any products or services to the member, while providing disease management services, unless the member signs a consent form providing NEMS with permission.

All information collected in the disease management program is confidential. The Disease Management team is prohibited from disclosing a member's medical information. All members of the team sign a confidentiality statement.

External Independent Review

Health plan members have the right to request an external independent review (EIR) from the Department of Managed Health Care (DMHC) if a request for investigational or experimental medical therapy is denied and meets the following criteria:

- Member has a life-threatening or seriously debilitating condition when the likelihood of death is high unless the course of the disease is interrupted.

- Member's physician certifies that the member has a condition that is seriously debilitating or life threatening, for which standard therapies have not been effective in improving the condition of the member.

- The member's physician has certified in writing that a treatment is likely to be more beneficial to the member than any available standard therapies.

When NEMS MSO receives a request for EIR from a provider or a member, NEMS MSO will instruct the member to contact the DMHC for EIR. The Health Plan will work closely with DMHC for a resolution. NEMS MSO will cooperate with the Health Plan and provide them with all medical information in support of the EIR. The medical information includes but is not limited to diagnosis, history and physical, treatment plan, progress notes, laboratory results, consultation reports from specialists, etc. DMHC will provide the Health Plan with a recommendation. The Health Plan will inform NEMS MSO of the resolution. Upon receiving the decision adopted by the DMHC that a disputed health care service is medically necessary, NEMS MSO will immediately contact the member and offer to promptly implement the decision.

Health Plan Notification

All UM approval and denial activities are reported monthly to the Health Plan as required.

Utilization Review for Over- or Under-Utilization

Aggregate TAR data is subject to retrospective analysis by the Utilization Management Committee. The review is designed to identify the practice patterns of individual providers relative to standards of medical practice to evaluate for over- or under-utilization of services.

Utilization data such as bed days/1000, readmission rate, length of stay, ER rate, etc. are reviewed quarterly in the UM/QI Meeting to identify over- or under-utilization of services.

Data indicating potential over or under-utilization are reviewed by the MSO Director and MSO Medical Director monthly. Over or under-utilization identified will be reported to the UM/QI Committee. Barriers, specific circumstances, and improvement opportunities are identified. Interventions are made to correct over- or under-utilization. Patient socio-economic status, language difficulties, education, staffing, and immunization programs are some areas considered. Interventions are measured and re-assessed through reports to the UM/QI Committee, until the UM/QI Committee determines that action plans have been effective and sufficient.

Inpatient Review

Hospital stays are reviewed by the UMC/Nurse for medical necessity. The patient's diagnosis, treatment plan, progress, discharge plan, etc. are evaluated to determine the medical necessity for inpatient hospitalization. Concurrent review should occur once every other day, or more frequently as needed. For elective hospital admissions, concurrent review is conducted for all extended days beyond the number of days originally authorized. Care shall not be discontinued

until a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient.

Newborn Care

Benefits include coverage for hospital and outpatient services for the month of birth and the month following birth under the mother's benefit. Providers caring for neonates with a potential California Children's Services (CCS) medically eligible diagnosis should contact NEMS MSO immediately so that referral can be made to CCS.

Transfer Policy

The NEMS MSO will work to coordinate and manage the care of members admitted out-of-area for emergency medical problems. The NEMS MSO will work to return the member to care within the NEMS MSO network as soon as medically appropriate. This policy may apply to members admitted to the hospital or or other levels of care, e.g., a skilled nursing facility (SNF).

After notification of an admission to an out-of-area hospital, The UM Coordinator begins to follow-up with hospital discharge planners. The UMC performs daily concurrent review and monitors the course of medical care until the patient is stable to be transferred to an in-network facility. At all times, appropriate level of services must be maintained.

Responsibilities of the UMC in the transfer process:
1. Works closely with hospital discharge planners in facilitating transfer/discharge
2. Contacts the member’s PCP as needed to coordinate transfer
3. Works closely with the transfer center at the in-network hospital for transfer
4. Makes arrangement for transport back to an in-network hospital
5. Issues authorization numbers for ambulance and inpatient admission to the in-network facility
6. Refers cases to UM Nurse/ Medical Director for review as needed

Care shall not be discontinued until a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient. The member's PCP shall become directly involved with facilitating the transfer as needed. This may involve communicating with the out-of-area hospital or emergency facility and making arrangement for transport back to an in-network hospital. If the NEMS MSO cannot be contacted, such as after business hours or on weekends, the PCP shall use his/her best judgment to authorize a reasonable transfer. The MSO should ascertain from the PCP whether he/she had been originally contacted for the out-of-network admission and if approval or denial was given.

Section III
Utilization Management Policies and Procedures

Policy 1: Access Standards

PURPOSE: To establish a process for compliance with the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) access standards.

POLICY:

1. This policy establishes compliance standards for member accessibility to primary, specialty, and ancillary care providers.

2. NEMS provides or arranges for the provision of health care services in a timely manner.

DEFINITIONS:

a) "Advanced access" means the provision, by an individual provider, or by the medical group to which a member is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advanced scheduling of appointments at a later date if the member prefers not to accept the appointment offered within the same or next business day.
b) "Ancillary service" includes, but is not limited to, providers of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, and home-health service providers.
c) "Appointment waiting time" means the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services, inclusive of time for obtaining authorization from NEMS MSO.
d) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.
e) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury, or other health condition.
f) "Specialty care provider" is defined as a residency-trained, board-certified, or board-eligible licensed practitioner who completed advanced training in a field recognized by the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA).
g) "Triage" or "screening" means the assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.
h) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

i) "Urgent care" means health care for a condition which requires prompt attention when the member's condition is such that the member faces an imminent and serious threat to his or her health, including but not limited to, potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.

PROCEDURES:

Members are offered appointments for covered health care services within a period appropriate for their condition. Providers will comply with the DMHC and DHCS access standards as follows:

Criteria	**Standard**
Initial Health Assessment (members ages 18 months and older)	Must be completed within 120 calendar days of enrollment
Initial Health Assessment (members ages < 18 months and younger)	Must be completed within 60 calendar days of enrollment
Initial prenatal care appointments	Within 14 calendar days of request
Emergency Care	Immediately
Urgent care appointment for services that do not require prior authorization	Within 48 hours of request
Urgent appointment for services that require prior authorization	Within 96 hours of request
Non-urgent primary care appointments	Within 10 business days of request
Non-urgent appointment with a specialist	Within 15 business days of request
Non-urgent appointment for ancillary services for diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of request
Triage or Screening (by phone)	Provide or arrange for the provision 24/7
Telephone Triage or Screening Waiting Time	Not to exceed 30 minutes
Wait time to speak to a customer service representative during normal business hours	Not to exceed 10 minutes
Wait time in office to see provider for scheduled appointments	Maximum of 30 minutes
If there is a provider shortage, arrange for the member to receive timely care as necessary for their health condition, if timely appointments are not available within network.	Per the standards for type of condition listed above

Criteria	Standard
Standing referral to a specialist if the primary care physician determines, in consultation with a specialist, NEMS Medical Director or Medical Director designee, that a member needs continuing care from a specialist. A 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 (PCP) with regular reports on the health care provided to the member.	Determination for standing referrals shall be made by NEMS Management Services Organization (MSO) within 3 business days from the date the request is made by the member or the member's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided.

EXCEPTIONS:

Extending Appointment Waiting Time:
The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

Preventive Care Services and Periodic Follow-up Care:
Preventive care services and periodic follow-up care including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Advanced Access:
A PCP may demonstrate compliance with the primary care time-elapsed access standards through implementation of standards, processes and systems providing advanced access to primary care appointments.

Appointment Rescheduling:
When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice and the objectives of this policy.

Other Applicable Requirements:

Telephone Triage or Screening Procedures

NEMS MSO requires its providers to maintain standard protocols and guidelines for processing calls from members that include:

- When the call should be immediately transferred to a licensed provider on duty
- When the member should be instructed to go to the emergency room
- Notification of emergency medical services (911) for emergency situations
- After-hours availability instructions
- Reasonable hours of operation and 24-hour access

24-Hour Access to Care

NEMS MSO requires its providers to have 24-hour access to care:

- A licensed physician or mid-level provider working under the supervision of the physician must be available for contact after-hours, either in person or via telephone 24 hours every day.
- All contacts must be documented in the member's permanent medical record.
- All documentation must be forwarded to the member's PCP of record.
- After-hours answering services or telephone system must include appropriate triage for emergency care. After-hours services will instruct members that if they feel they have a serious acute medical condition, they should seek immediate care by calling 911 or going to the nearest emergency room.
- Health Plan members may use Health Plan's Nurse Advice Line for triage services if available.

Missed Appointments

NEMS MSO will require its providers to have processes in place to follow-up on missed appointments that include the following:

- Notation of the missed appointment in the member's medical record
- Review of the potential impact of the missed appointment on the member's health status including review of the reason for the appointment by a licensed clinician.
- Notation in the chart describing follow-up for the missed appointment including one of the following actions: no action if there is no effect on the member due to the missed appointment, a letter or phone call to the member as appropriate given the type of appointment missed and the potential impact on the member. The chart entry must be signed or co-signed by the member's assigned PCP or covering clinician.
- Three attempts, at least one by phone and one by mail must be made in attempting to contact a member if the member's health status is potentially at significant risk due to missed appointments. Examples include members with serious chronic illnesses, members with test results that are significant (e.g., abnormal PAP smear) and members judged by the treating physician to be at risk for other reasons. Documentation of the attempts must be entered in the member's medical record, and copies of letters must be retained.

Unusual Specialty Services
NEMS MSO and its providers shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within their network, when determined medically necessary.

Redirection of Care
NEMS MSO will ensure that members receive appropriate medically necessary services when a provider objects to providing the services. NEMS MSO will respond with a timely redirection referral and coordination if a benefit/covered service is not available from one of their providers because of a religious, ethical or moral objection to the covered service by that provider. NEMS MSO will allow a member to complain about any "provider objection" and help the member contact the Health Plan, which will follow DHCS and DMHC standards for member grievance and/or appeal procedure to acknowledge and resolve the member's complaint.

Non-Emergency Medical Transport (NEMT)
NEMS MSO will provide ambulance, litter van, and wheelchair van transportation services when the member's medical and physical condition is such that transport by ordinary means of public and private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care rendered by licensed providers (refer to NEMT policy).

Communication of Guidelines
NEMS MSO will inform the contracted provider network of the access standards via policy and procedure documents or other recognized methods.

Compliance Monitoring
NEMS MSO will monitor access standards through monitoring of complaints and grievances. Complaints and grievances are reviewed by the NEMS MSO Utilization Management/ Quality Improvement Committee. Standards will be reviewed/revised annually or as necessary.

Policy 2: Adult Day Health

PURPOSE: NEMS providers identify members who are at risk for institutional placement, refer these members for adult day health services, and coordinate care of such members with the waiver service providers.

POLICY:
Primary Care Providers (PCPs) identify members who are currently residing in the community and are at risk for institutional placement. PCPs notify NEMS MSO case managers of candidates for referral and will note referrals to adult day health centers in members' medical records.

PROCEDURES:
NEMS MSO case manager responsibilities include:

- Conducting concurrent hospital reviews to identify members who meet the general criteria and would benefit from referral to an adult day health center.

- Reviewing cases identified by providers as candidates for adult day health center referrals.

- Assessing the needs, functional limitations, and socioeconomic status of identified members. Case managers will assess the member's medical status, health history, psychosocial needs, home environment, and formal and informal support systems.

- Contacting the local adult day health programs to determine availability of required referral or services. Programs generally serve those within their neighborhood areas. For specific information, contact Senior Central:

Central City/Potrero Hill	(415) 777-3233
Western Addition/Marina	(415) 567-3900

- Notifying the member's PCP of member acceptance to an adult day health program.

- Continuing case management of care to members who require adult day health services or when placement is not available.

PCPs continue to case manage and provide all medically necessary care to members regardless of their referral to an adult day health center and will coordinate care with adult day health providers. PCPs shall provide medical records upon request to the adult day health center when members are referred and to service providers when members enter care.

When there are difficulties in assuring a smooth continuum of services to the member, the NEMS MSO case manager will contact the Health Plan's case manager for additional case oversight and assistance.

Policy 3: Alcohol and Substance Use/ Screening, Brief Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

PURPOSE: NEMS is required to provide all preventive services consistent with the United States Preventive Services Task Force (USPSTF) Grade A and B recommendations. The USPSTF assigned a Grade B recommendation for screening for unhealthy alcohol use in primary care settings in adults, 18 years and older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

POLICY:

1. Beginning January 1, 2014, NEMS will cover an expanded alcohol screening for members 18 years of age and older who answer "yes" to the alcohol question in the Staying Healthy Assessment (SHA), or at any time the Primary Care Provider (PCP) identifies a potential alcohol misuse problem.

2. NEMS covers brief intervention(s) for members who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder. Any member identified with possible alcohol use disorders should be referred to the alcohol and drug program.

DEFINITIONS

a) **Screening, Brief Assessment, Brief Intervention and Referral to Treatment (SABIRT)** means comprehensive, integrated delivery of early intervention and treatment services for persons with substance abuse disorders, as well as those who are at risk of developing these disorders. Primary care settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

b) **Brief Assessment** means when a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validating alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools included, but are not limited to:
   - NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
   - Drug Abuse Screening Test (DAST-20)
   - Alcohol Use Disorders Identification Test (AUDIT)

c) **Brief Intervention** means a provider interaction with a patient that is intended to induce a positive change in a health-related behavior. Brief intervention may include an initial intervention, a follow-up intervention and/or a referral.

d) **Alcohol use disorder** means that a patient meets the criteria in the *Diagnostic and Statistical Manual* (DSM) for a substance use disorder resulting from alcohol use.

PROCEDURES:

1. PCPs screen members as part of routine care for alcohol misuse. Providers may use the following tools when screening for alcohol misuse.
    - SHA form
    - The Alcohol Use Disorders Identification Test (AUDIT)
    - The abbreviated AUDIT-Consumption (AUDIT-C)
    - A single-question screening, such as asking, "How many times in the past year have you had 4 (for women and all adults older than 65 years) or 5 (for men) or more drinks in a day?"
2. PCPs refers members identified with possible alcohol use disorders to the alcohol and drug program in the county where the member resides for evaluation and treatment.
3. Provider Requirements
    a. **Screening:** when a member answers "yes" to the SHA alcohol pre-screen question, NEMS MSO will ensure that the PCP offers the member an expanded, validated alcohol screening questionnaire at least once a year. NEMS MSO will ensure that PCPs maintain documentation of the SHA and the expanded screening. When a member transfers to another PCP, the receiving PCP may obtain prior records. If no documentation is found, the PCP must provide and document this service.
    b. **Brief Assessment:** when screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validating alcohol and drug assessment tools may be used without first using validated screening tools.
    c. **Brief Intervention**: NEMS MSO will ensure that providers offer brief intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use when a member responds affirmatively to the alcohol question in the SHA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified.

       Brief intervention(s) typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities. Providers may refer offsite for brief interventions; however, NEMS MSO will encourage PCPs and their teams to offer the service within the primary care clinic, to increase the likelihood of members following through on the interventions. NEMS MSO will allow each member at least three brief intervention sessions per year. Providers may combine these sessions in one or two visits or administer the sessions as three separate visits.
    d. **Referral to treatment**: NEMS MSO will ensure that members who are found, upon screening and evaluation, to meet criteria for an alcohol use disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), or whose diagnosis is uncertain, are referred for further evaluation and treatment. Treatment for alcohol use disorders is not a service covered by NEMS MSO as they are carved out services covered by Mental Health.

4. Communicate training and scope of practice requirements to providers.

- PCPs are to assess Health Plan members for alcohol and drug use and make appropriate referrals for treatment. Members will be referred to the Health Plan's Mental Health

services if he/she meets the specialty Mental Health criteria. When appropriate, PCPs shall discuss recommendations for alcohol and/or drug treatment with the member and develop a treatment plan.

- PCPs will provide medically necessary care for members with physical problems related to substance abuse or who require admission for a medically unstable condition due to alcohol or other substances.

- When requested, PCPs shall forward medical records, subject to the member's written consent, to alcohol and drug treatment providers and request a summary of services be sent back for inclusion in the member's medical record. The PCP will follow standard procedures to ensure confidentiality of patient information in accordance with State law and professional practice standards.

- NEMS MSO will assist the PCP in making referrals for alcohol and drug treatment services and when appropriate, provide case management services to assist PCPs in the coordination of member care to help avoid member utilization of inappropriate services (e.g., unnecessary ER utilization).

References:

- Department of Health Care Services (DHCS) All Plan Letter (APL) 17-016: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-016.pdf
- Department of Health Care Services All Plan Letter 18-014: Alcohol Misuse
- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-014.pdf

Policy 4: California Children's Services (CCS)

The California Children's Services (CCS) program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions.. Services provided under the CCS program are reimbursed through the CCS program. The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services (DHCS). NEMS MSO is not financially responsible for the services that CCS provides to its members. A NEMS MSO member who is eligible for CCS services remains enrolled with NEMS MSO, and the member's PCP continues to coordinate and provide primary care and all other services unrelated to the CCS-eligible condition.

POLICY

Physicians and NEMS MSO are responsible for identification, referral, and case management of members with CCS-eligible conditions. The CCS program, while not an insurance plan, does provide services in the following areas:

- Diagnosis and treatment for children meeting program eligibility requirements
- Medical Therapy Program that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.
- High Risk Infant Follow-up Program for infants discharged from a neonatal intensive care unit (NICU) and at risk for a CCS-eligible condition.
- Eligible conditions include physical disabilities and complex medical conditions such as sickle cell anemia, cancer, diabetes, HIV, major complications of prematurity, etc.

In general, CCS reimburses only for secondary and tertiary care related to the child's CCS-eligible condition. CCS reimburses only CCS paneled providers and CCS-approved hospitals within the health plan's network, and only for services from the date of referral. All reimbursed services are subject to prior authorization by the local CCS program.

PCPs are responsible for identifying health plan members with potential CCS-eligible conditions and initiate evaluation per CCS program standards. PCPs facilitate immediate referrals of all potential or actual CCS cases to CCS, not to exceed one business day from date of identification.

PROCEDURE

When an evaluation for a possible CCS-eligible condition is undertaken:

The PCP shall follow the NEMS MSO referral and authorization policies and procedures in coordinating pre-referral evaluations and referral to CCS for eligibility evaluation. Whenever possible, PCPs are encouraged to refer to CCS specialty providers within the NEMS MSO and health plan network. A list of CCS certified providers and practitioners will be maintained and available for reference. The PCP is responsible for performing appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS-eligible medical condition. The PCP

and NEMS MSO are responsible for assuring that minimum pre-referral evaluation standards are met.

Initial CCS referrals can be made to the local CCS program by telephone, same-day mail or fax. The initial referral should be followed by submission of supporting medical documentations sufficient to allow for eligibility determination by the local CCS program. Referrals for specialty CCS services must contain:

- Pertinent history and physical examination information specific to the abnormality in question
- Reasons for PCP concern
- Service(s) being requested
- If pertinent, the name of the CCS-paneled specialty provider to whom patient is being referred

PCPs are to alert the member's medical group of the CCS referral. CCS referrals for program eligibility do not require prior authorization by the NEMS MSO. The PCP may refer a potential CCS case to NEMS MSO for review.

When NEMS MSO receives an authorization request for a condition that may qualify for the CCS program, the UMC will perform the following:

1. Verify that the member meets age and residency requirements to qualify for the CCS program.
2. Check the CCS Medical Eligibility List to ensure the medical condition meets CCS program criteria and the required tests are completed.
3. Check CCS provider website to determine if the treating physician is a CCS-paneled provider.
4. 4. Check if the case is approved by CCS and if the approval is still active.

5. If the case is approved by CCS, the UMC informs the PCP of the approval and faxes the CCS approval letter to the PCP. 6. If there is no existing CCS approval and member meets eligibility and medical criteria, inform the requester to apply for CCS. For urgent referral, the UMC may submit the referral to CCS directly and follow up with CCS by phone as needed.
7. CCS services should be provided by CCS-paneled providers. Confirm that the treating provider is a CCS-paneled provider by checking the CCS provider list on the CCS website:
   - **Website:** https://www.dhcs.ca.gov/services/ccs
   - **Provider Lists:** https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx
8. Provide PCP with a temporary case number to proceed with the requested treatment.
9. Change case status to "deferred" to indicate the case has been referred to CCS and the CCS status is pending.
10. Log the case and the temporary case number in the CCS log.
11. Check the CCS provider website for approval/denial/pending status as frequently as needed.
    - If case is approved by CCS, the temporary case number remains as a reference number with notes indicating that CCS has approved the case. The case remains in "deferred" status.
    - If case is denied by CCS, the UMC changes the case status to "approved." The service is now approved by NEMS MSO. The reason for CCS's denial is recorded.

- If case is pended by CCS for more medical information, the UMC obtains the additional information from the provider or the hospital discharge planner and submits to CCS for review.

The PCP and NEMS MSO continue to provide all medically necessary covered services for the member's CCS-eligible condition until CCS eligibility is confirmed. NEMS MSO remains responsible for the provision of all medically necessary covered services to the member if the local CCS program does not approve the CCS eligibility. If the local CCS program denies authorization for any service, NEMS MSO remains responsible for obtaining the medically necessary service and paying for the service if it has already been provided.

Once a member is enrolled in the CCS Program:

The PCP manages the health care of the member and coordinates services with CCS to ensure that the member receives all medically necessary care. Whenever possible, PCPs are encouraged to refer the member to CCS specialty providers within the NEMS MSO and Health Plan network.

The PCP and/or CCS-paneled provider is responsible for submitting requests for services to the CCS program, which has the exclusive right to determine medical necessity for the program. All CCS funded services are subject to prior authorization by the CCS program. If a member is hospitalized for his/her CCS-eligible condition, the local CCS program must pre-authorize the scheduled admissions or be notified on the day of the admission when urgently or emergently admitted. The member's supporting clinical information and the CCS referral form are sent to the local CCS program by telephone, same-day mail, or fax.

The PCP must continue to provide all medically necessary covered services that are unrelated to the member's CCS-eligible condition. The PCP is responsible for coordinating services with CCS specialty providers and the local CCS program. The PCP may refer members with complex needs to NEMS MSO for case management services.

Case Management for CCS Members

Periodic Management
The UMC and Nurse Case Manager manage the care of CCS-eligible members throughout the course of their CCS eligibility.

When performing inpatient concurrent reviews, the Nurse Case Manager coordinates care with the hospital discharge planner to identify any discharge planning needs, such as transfer to a skilled nursing facility or discharge to home with durable medical equipment and visiting nurse. Within seven days of hospital discharge, the Nurse Case Manager contacts the member to transition the care of the member.

When reviewing requests for outpatient services, the UMC identifies issues that may arise and works closely with PCPs, specialists, members/families, and CCS to make sure that members receive appropriate care. Examples of issues that may arise include frequent emergency room visits, missing PCP or specialist appointments, needing mental health referral or referral to

community resources, etc. The UMC may refer the case to the Nurse Case Manager for case management.

Case Management

When appropriate, NEMS MSO will provide case management services to assist PCPs in the coordination of the member's care. Source of referral may include case finding through review of utilization data and referral by PCP, other providers, or family members. Case management activities may include the following:

- Assist the PCP in the coordination of care between inpatient and outpatient settings, and with out-of-plan providers and their services (e.g., CCS-funded specialty care, mental health, and substance abuse treatment services).
- Provide ongoing case management and monitoring of high-risk members.
- Provide community resources information to the provider and member.
- Document case management plans, including PCP approval, and ongoing communication between the case manager and PCP.
- Assist the member to safely transition coverage of medically necessary services that were previously covered by CCS to NEMS coverage for members who are no longer eligible for CCS at 21 years of age.
- Coordinate with the treating provider and member to ensure that members aging out of CCS at age 21 continue to receive medically necessary services through NEMS without a gap or delay in care.

Please refer to policies and procedures on Case Management for comprehensive case management activities.

Age-Out Transition

Upon receiving CCS age-out transition referral, NEMS MSO will contact the member to safely transition coverage of medically necessary services that were previously covered by CCS to NEMS coverage. The transition process shall include the following:

- Timely opening of cases and outreach to members – 3 months prior to CCS age-out date
- Documentation of consent to speak with parent/guardian
- Documentation confirming CCS Exit Summary has been reviewed prior to member's CCS age-out date
- Assessment of member's needs and scope of transition coordination intervention
- Documentation of provider outreach and coordination, which includes PCP, specialists, and vendors

Tracking CCS Members in the UM System

The Health Plan provides CCS member lists to NEMS MSO on a scheduled basis. Case management (CM) staff will verify member's current case status on the CCS provider website. Active CCS members will be marked in the NEMS MSO UM system as CCS members, enabling an alert to appear and notify the UM and CM staff about member's CCS status. UM

and CM staff will follow-up with members, providers, and CCS's case managers as needed to coordinate care.

CCS Log

NEMS MSO shall maintain a log of CCS activities. The UMC is responsible for completing and keeping the log updated. The log will list the following:

1. All potential CCS-eligible members. This will include members judged potentially eligible through review of the member's medical history or utilization data, or through referral by the PCP.
2. CCS case status for all members who were referred to CCS.

The monthly log will contain the following information:

1. Log entry date
2. Member name, Health Plan ID number, and date of birth
3. PCP name
4. Type of Case Management activity (e.g., CCS)
5. Temporary case number assigned
6. Date identified as potentially eligible, date of referral to CCS, and date of response from CCS
7. Notes about the case, e.g., diagnosis, CM goals, communications, outcome, CCS case number (if applicable), disposition
8. Status (open/closure date)
9. NEMS staff name
10. Member almost 21 years old with transition plan and assigned case manager (Yes/No)

The UMC will document appropriate and timely referral of potential cases in the CCS Log. The member's progress and outcome of CCS referral are tracked at least monthly or sooner and is documented on the log. The UMC will ensure there is appropriate notification of approved and denied cases to the referring provider and track the outcome and progress of denied cases to ensure that members continue to receive appropriate care.

NEMS MSO shall be responsible for the quarterly review of the CCS Log by the responsible UM physician. Reports shall be submitted to the Health Plan quarterly as required and presented to the Health Plan during the annual audit.

References:
DHCS CCS Program website
https://www.dhcs.ca.gov/services/ccs

Policy 5: California Programs Training

The NEMS Provider Relations staff are responsible for educating new hires, providers, and staff, including annual updates of the California programs.

POLICY
NEMS provides training to new hires, providers, and staff, including annual updates of the California programs.

PROCEDURE
1. The following California programs are included in the Summary of Key Information:

- California Children's Services (CCS) Program
- Comprehensive Perinatal Services Program (CPSP)
- Child Health & Disability Prevention (CHDP) Program
- Sterilization Consent
- Department of Developmental Services (DDS) – Early Start (ES) Program, Regional Center, etc.
- Initial Health Assessment (IHA) & Individual Health Education & Behavioral Assessment (IHEBA)
- Language Assistance Program (LAP)

2. The NEMS Provider Relations team updates the Summary of Key Information annually to include any changes to the California programs.
3. The NEMS Provider Relations team provides training to new hires, providers, and staff on the above California programs.
4. Provider Relations keeps record of the training materials which include the following items:
    - Handouts for CCS, CPSP, CHDP, Sterilization Consent, Carved Out Services (DDS), IHA/IHEBA, LAP-including health plan resources
    - Sign-in logs and agendas

Policy 6: Carve-out Services and Coordination of Care

Certain health services for members are carved-out from the Health Plan and require coordination with other resources, e.g., mental health, substance abuse, alcohol detoxification, dental, etc. Coordination and collaboration between PCP and the referred service, including referral to the program, is documented in the member's health record.

1. Comprehensive Case Management Including Coordination of Care Services

The PCP continues to provide all medically necessary covered diagnostic, preventive, and treatment services to the member. The NEMS Case Management (CM) team provides case management, discharge planning, disease management and coordination of care to members, including but not limited to all medically necessary services delivered both within and outside NEMS provider network. The CM team coordinates care with the carved-out providers/agencies to ensure the member receives care he/she needs (Refer to policy on Case Management).

2. Discharge Planning and Care Coordination

NEMS shall ensure the provision of discharge planning when a SPD beneficiary is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:

- Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.
- Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports.
- Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
- Summary of the nature and outcome of SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

3. Targeted Case Management Services (TCM)

NEMS is responsible for determining whether a member requires Targeted Case Management (TCM) services and must refer members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.

If a member is receiving TCM services as specified in 22 CCR 51351, NEMS shall be responsible for coordinating the member's health care with the TCM provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM provider that are covered services.

4. Disease Management Services

NEMS is responsible for initiating and maintaining disease management services for Members who are at risk of adverse health outcomes and/or higher utilization of services. NEMS shall determine the program's targeted disease conditions and implement a system to identify and encourage Members to participate.

5. Out-of-Network Case Management and Coordination of Care

NEMS identifies individuals who may need or who are receiving services from out-of-network providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for carved out services.

6. Mental Health Services

PCPs are responsible for treating patients for mental health concerns within the scope of his/her primary care practice, prescribing medications, screening patients for more extensive mental health services and ensuring timely referral to mental health services. Medi-Cal members' mental health services provided outside of the primary care practice continue to be covered as a separate benefit through the Health Plan's mental health providers. Mental health services will be determined through medical necessity.

Medi-Cal managed care plans are responsible for specific non-specialty mental health services. These services include individual and group mental health evaluation and treatment, psychological testing, certain outpatient services to include laboratory drugs, supplies, supplements, and psychiatric consultation. For example, Beacon Health Options manages mild-to-moderate behavioral health benefits and behavioral health therapy (BHT) benefits for SFHP Medi-Cal members.

Mild to moderate mental health benefits include:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing, when clinically indicated to evaluate a mental health condition (prior authorization required)
- Outpatient services for the purpose of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies, and supplements
- Evaluation for Autism Spectrum Disorder
- BHT for those under 21 diagnosed with Autism Spectrum Disorder

To refer a member for mild and moderate mental health services for SFHP members, call Beacon's toll-free Access Line at 1(855) 371-8117 (toll-free) or 1(800) 735-2929 (TDD/TTY), 24 hours a day, 7 days a week.

Specialty Mental Health

All Specialty Mental Health Services (inpatient and outpatient) are excluded.

The case management (CM) team should make appropriate referrals for members needing Specialty Mental Health Services as follows:

- For those members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the county mental health plan, as defined in PL 00-001 Revised and APL 13-021, the member shall be referred to the county mental health plan.
- For those members whose mental health diagnosis is not covered by the county mental health plan, because the adult member's level of impairment is mild to moderate, or the recommended treatment for adult and child members do not meet the criteria for Specialty Mental Health Services, the member shall be referred to an appropriate Medi-Cal mental health Provider within Health Plan's provider network. The CM team shall consult with the county mental health plan as necessary to identify other appropriate community resources and to assist the member to locate available non-covered mental health services.
- Any disputes between mild and moderate mental health agency and the county mental health plan shall be addressed by the health plan. The CM team notifies the health plan to achieve a timely and satisfactory resolution.

For SFHP members: Specialty mental health conditions and alcohol and drug abuse are provided by San Francisco Behavioral Health Services (SFBHS). To refer a member for specialty mental health services, call SF BHS at 1(888) 246-3333**.**

For health plans in counties other than San Francisco, the mental health providers are specific for the health plan. NEMS will refer members to mental health providers as specified by the health plan.

When UM receives a request for authorization of behavioral health, the UM team determines whether NEMS is delegated for mental health services. If mental health services are not delegated, the UM team notifies the requester about the carved out mental health benefit and provides the requester with contact information for mental health.

If mental health services are delegated to NEMS, the UM team will review the request based on written UM criteria that are consistent with accepted standards of practice. The UM criteria and its hierarchy can be found in the "UM Criteria" section in this manual. Guidelines may include Medi-Cal guidelines, Health Plan guidelines, and MCG. The UM team may send the case to an external reviewer for review if guidelines are not available.

The UM criteria should be available for the following mental health parity conditions:

- Schizophrenia
- Schizoaffective disorder

- Bipolar disorder (manic depressive illness)
- Major Depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia Nervosa
- Bulimia Nervosa
- Severe Emotional Disturbances of Children

If the request was deemed not medically necessary after review of information, the NEMS MSO physician reviewer will consult a psychiatrist for denial of behavioral health care that is based on medical necessity.

Behavioral Health Treatment Coverage for Members Under the Age of 21

Beacon provides behavioral health treatment (BHT) for all SFHP members under 21. BHT services teach skills through behavioral observation and reinforcement to help develop or restore, as much as possible, members' daily functioning. A physician or a licensed psychologist must recommend that BHT services are medically necessary. To ask about BHT services, call Beacon Health Options at 1(855) 371-8117 (toll-free) or 1(800) 735-2929 (TDD/TTY), 24 hours a day, 7 days a week.

All children enrolled in Medi-Cal must receive EPSDT screenings designed to identify health and developmental issues as early as possible at regular intervals in accordance with recommendations for preventive pediatric health care developed by the American Academy of Pediatrics "Bright Futures" guidelines. When a screening examination indicates the need for further evaluation of a child's health, the child must be appropriately referred for medically necessary diagnosis and treatment without delay.

Effective July 1, 2018, Health Plans are responsible for providing medically necessary BHT services for all members that meet the eligibility criteria (below) for services, even without a diagnosis of ASD, based upon medical necessity as determined by a licensed physician or a licensed psychologist. The authorization and payment of BHT services will transition from the RCs to the Health Plans. Health Plans do not delegate Behavioral Health services including BHT services.

<u>Criteria for BHT services:</u>
In order to be eligible for BHT services, a Medi-Cal member must meet all of the following coverage criteria:

1. Be under 21 years of age
2. Have a recommendation from a licensed physician or a licensed psychologist that evidence-based BHT services are medically necessary
3. Be medically stable
4. Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID)

<u>Covered services:</u>
Medi-Cal covered BHT services must be:

1. Medically necessary to correct or ameliorate behavioral conditions as determined by a licensed physician or licensed psychologist
2. Delivered in accordance with the member's Health Plan-approved behavioral treatment plan
3. Provided by California State Plan approved providers
4. Provided and supervised according to a Health Plan-approved behavioral treatment plan developed by a credentialed BHT service provider. BHT services are provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific member being treated and that has been developed by a BHT Service Provider.

The behavioral treatment plan is reviewed, revised and/or modified at least every 6 months. The following services **do not** meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:

1. Services rendered when continued clinical benefit is not expected.
2. Provision or coordination of respite, daycare, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
3. Treatment whose sole purpose is vocationally- or recreationally-based.
4. Custodial care. For purposes of BHT services, custodial care:
    - Is provided primarily for maintaining the member's or anyone else's safety.
    - Could be provided by persons without professional skills or training.
5. Services, supplies or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas and camps.
6. Services rendered by a parent, legal guardian or legally responsible person.
7. Services that are not evidence-based behavioral intervention practices.

NEMS informs contracted practitioners about BHT via the Summary of Key Information document.

Behavioral Health Treatment for Anthem Blue Cross (ABC)

ABC has developed a referral form to be used when a physician identifies a Medi-Cal member who may benefit from BHT services. The form must be signed by the physician. The physician may contact the Behavioral Health intake line (**1-888-831-2246** option **1**; then option **2** and request a case manager to assist the member/parent in finding an applied behavior analysis (ABA) provider). If the parent has already identified an ABA provider and requested a referral, the signed referral form may be given to the parent to present to the ABA provider. Please see attached for the *ABA Referral Form*, *Anthem Case Management Referral Form,* and Anthem's *Behavioral Health Quick Reference Guide*.

Reference: Department of Health Care Services, *APL 18-006*; *APL 18-007* and *APL 18-008*

Crisis Intervention Information

San Francisco County

- Comprehensive Child Crisis Service – This emergency program provides children and youth and their families with crisis intervention, evaluation for hospitalization, consultation, home visits, short-term psychotherapy, and referrals to community treatment

programs. All referrals to hospitals for psychiatric admissions must be evaluated by Child Crisis Service.
24-hour hotline (415) 970-3800

- Mobile Crisis Team – The Mobile Crisis Team provides emergency and urgent mental health evaluation and crisis intervention. Telephone numbers (415) 970-4000, (415) 255-3737 (24-hour access helpline), (888) 246-3333, and (888) 484-7200 (TDD) Address: 1380 Howard St., 5th floor, SF., CA 94103.

- Crisis Line – San Francisco Suicide Prevention's 24 hour Crisis Line provides immediate crisis intervention and emotional support to everyone who calls.

Crisis Line: 415-781-0500 or 1-800-273-8255
Crisis Text Line: 24/7 Confidential Support, Text MYLIFE to 741741

San Mateo County
• 24/7 Child and Teen Hotline (650) 567-KIDS (5437) for parents, educators and youth
• 24/7 Parent Support Line (650) 579-0358
Crisis Intervention and Suicide Prevention Hotline (650) 579-0350 | (800) 273-TALK (8255)
• Crisis Text Line Text HOME to 741741 | www.crisistextline.org
San Mateo County Behavioral Health and Recovery Services ACCESS Call Center (800) 686-0101 or TTY for hearing impaired: dial 711

Teen Crisis Services
Monday – Thursday, 4:30 – 9:30 p.m. PST
Teen Text Line: 650-747-6463
Teen Chat: sanmateocrisis.org

Suicide Crisis Hotlines
- 1-800-273-TALK (8255) – National Suicide Prevention Lifeline
- 650-579-0350 | sanmateocrisis.org – StarVista's 24/7 Crisis Hotline (San Mateo County)
- Text "BAY" to 741741
- Teen Text Line: 650-747-6463 and Chat sanmateocrisis.org available Monday-Thursday, 4:30-9:30 p.m. PST

Santa Clara County
Uplift Family Services' Mobile Crisis Team – provides 24-hour intervention to children and teens in the community who are in acute psychological crisis.

24-hour/7 days a week crisis line
Toll-free: 1-877-41-CRISIS (412-7474)
Phone: 1 (408) 379-9085
Website: https://upliftfs.org/service/continuum-of-crisis-care/

Mobile Crisis Response Team (MCRT)

These teams respond to individuals in crisis that exhibit mental health symptoms, may be suicidal or at-risk and need an evaluation for psychiatric hospitalization. Teams are made up of licensed clinicians and therapists with training and expertise in crisis response.

Santa Clara County residents may call the Mobile Crisis Response Teams at 1-800-704-0900, Monday – Friday, 8:00 a.m. – 8:00 p.m., select option #2 to request a Mobile Crisis Response Team member.

Mobile Crisis Response Teams screen and assess crisis situations over the phone and intervene wherever the crisis is occurring. They provide an immediate response and deliver crisis intervention services at locations throughout the county.

Suicide and Crisis Hotline 24/7: 1-855-278-4204 or text RENEW to 741741
Suicide Prevention Lifeline 24/7: 1-800-273-8255

Psychiatric Hospitalization

Emergency hospital admissions: Emergency psychiatric conditions exist when a Medi-Cal or Healthy Families member requires voluntary or involuntary hospitalization because he/she meets the criteria for medical necessity for psychiatric inpatient hospital services and presents, as a result of a mental disorder, as: a danger to self or others, or immediately unable to provide for, or utilize food, shelter, or clothing. No prior authorization for payment from the county's Mental Health Plan (MHP) will be required for emergency services. In the event of an emergency psychiatric admission, hospitals are required to notify the MHP within 24 hours of the time of the admission of the member to the hospital, or within the timelines specified in the contract, if applicable. Emergency admissions must meet the criteria specified above.

After an emergency admission, the MHP of the member may:

(1) Transfer the beneficiary from a non-contract to a contract hospital or a hospital owned or operated by the MHP of the beneficiary as soon as it is safe to do so. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

(2) Choose to authorize continued stay with a non-contract hospital.

Planned Hospital Admissions: For psychiatric conditions that do not meet emergency criteria all planned hospital admissions must be prior authorized by the MHP.

Prescriptions for Psychiatric Medications
Health plan covers prescribed, medically necessary psychiatric medications for Medi-Cal members. However, the state has carved out antipsychotics and these are covered by the Medi-Cal Fee-for-Service (FFS) program and are billed to Medi-Cal FFS by the pharmacy. The specific carved out drugs can be found in the Health Plan Formulary.

When a PCP receives calls regarding medications for their patients who are also served by the MHP, the PCP may accommodate these requests. Any prescription benefit questions or problems should be addressed to the Medical Director at the Health Plan

Role of Primary Care Provider (PCP)
The PCP is responsible for assessing members for the occurrence of mental health disorders. The PCP may refer members with mental health disorders who meet medical necessity criteria to the following Access Call Centers:
-Community Behavioral Health Services for residents of San Francisco
24-hour Access Helpline: (415) 255-3737 or (888) 246-3333 or TDD (888) 484-7200

-Behavioral Health and Recovery Services for residents of San Mateo County
(800) 686-0101, TTY (for hearing impaired): dial 711

-Mental Health Services for residents of Santa Clara County
(800) 704-0900

The PCP is responsible for providing mental health treatment to patients when the patient has an uncomplicated mental health disorder.

PCPs should consider requesting consultation and/or treatment by a mental health provider in the following situations:

- The patient presents with a level of potential danger to self or other, or with an impairment of functioning which is beyond the clinical skills or experience of the referring primary care provider.
- The mental health treatment provided by the referring primary care provider for the disorder has not produced adequate symptomatic improvement.
- The existence, nature or proper treatment of the mental disorder is unclear to the referring PCP.

If the patient does not meet medical necessity criteria, the patient will be referred back to the PCP with specific recommendations on how they can manage the patient's mental health problems.

In cases where medical necessity is disputed or questionable, the PCP should call the Medical Director of the Health Plan.

In the event of a member complaint related to denial of mental health services, the complaint should be directed to MPS at the Health Plan. For Medi-Cal members, a complaint about carved-out mental health services provided by SFMHP should be directed to SFMHP's Quality Improvement Office at 415-252-3033..

7. Alcohol and Substance Use Disorder Treatment Services

Alcohol and substance use disorder treatment services are available under the Drug Medi-Cal program as defined in Title 22 CCR 51341.1, and outpatient heroin detoxification services defined in Title 22 CCR 51328 are excluded benefits. These Excluded Services include most medications used for the treatment of alcohol and substance use disorders covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through the Medi-Cal FFS Program. To the extent a pharmacy is seeking Medi-Cal FFS reimbursement for medications for the treatment of Alcohol and Substance Abuse that are listed in the Medi-Cal

Provider Manual, MCP: Geographic Managed Care, Capitated/Non-capitated Drugs section, when these medications are provided by a pharmacy, the pharmacy must be enrolled as a Medi-Cal provider in the Medi-Cal FFS program to qualify for Medi-Cal FFS reimbursement.

NEMS shall identify individuals requiring alcohol and or substance use disorder treatment services and arrange for their referral to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin detoxification Providers available through the Medi-Cal FFS program, for appropriate services. NEMS shall assist members in locating available treatment service sites. To the extent that treatment slots are not available within the NEMS's Service Area, NEMS shall pursue placement outside the area. NEMS shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance use disorder treatment and coordinate services between the Primary Care Providers and the treatment programs.

PCPs are to assess health plan members for alcohol and drug use and make appropriate referrals for alcohol and drug treatment services. When appropriate, PCPs shall discuss recommendations for alcohol and/or drug treatment with members and develop a treatment plan. Referrals may be made to any one of the following programs for an acute episode or ongoing treatment based on the member's requirements for level of care: Acute Detoxification Program, Acute Inpatient Program, Residential Program or Outpatient Program.

PCPs will provide medically necessary care for members with physical problems related to substance abuse or who require admission for a medically unstable condition due to alcohol or other substances.

When requested, PCPs shall forward medical records, subject to the member's written consent, to alcohol and drug treatment providers and request a summary of services be sent back for inclusion in the member's health record. The PCP will follow the Health Plan's standard procedures to ensure confidentiality of patient information in accordance with State law and professional practice standards.

NEMS MSO will assist the PCP in making referrals for alcohol and drug treatment services and when appropriate, provide case management services to assist PCPs in the coordination of a member's care to help avoid member utilization of inappropriate services (e.g., unnecessary ER utilization).

Alcohol and drug treatment services remain available under a separate Fee-for-Service Medi-Cal program and are not a plan benefit. . When the member is physically stable, they are to be transferred to a Medi-Cal funded drug treatment program. PCP team will continue to case manage the health care of the member and coordinate services with alcohol and drug treatment providers.

Providers may call the following telephone numbers for referral of members in:
San Francisco: M-F from 9:30 a.m. – 3 p.m. 415-503-4730, 800-750-2727

San Mateo County: Access Call Center 24/7 for assistance: (800) 686-0101
TTY for the hearing impaired - dial 711

Santa Clara County:
Youth – M-F from 9 a.m. – 6 p.m. (408) 272-6518
Gateway Call Center for Adults – M-F from 8 a.m. – 5 p.m. (800) 488-9919

Please refer to the policies and procedure on "Alcohol Misuse" for more details.

8. Services for Children Who Are Under 21 Years of Age with Special Health Care Needs

NEMS implements and maintains services for Children with Special Health Care Needs (CSHCN) that include but are not limited to, the following:

1. Standardized procedures that include health care provider training for the identification of CSHCN, at enrollment and on a periodic basis thereafter.
2. Ensuring and monitoring timely access through the annual Provider Appointment Availability Survey (PAAS) to pediatric Specialists, sub-Specialists, ancillary therapists, community resources, and specialized equipment and supplies.
3. Ensuring that each CSHCN receives a comprehensive assessment of health and related needs, and that all medically necessary follow-up services are documented in the medical record, including needed referrals.
4. Case management or care coordination of services for CSHCN, including coordination with other entities that provide services for CSHCN (e.g. mental health, substance use disorder, Regional Center, CCS, local education agency, child welfare agency).
5. Monitoring and improving the quality and appropriateness of care for CSHCN.

9. California Children's Services (CCS)

Services provided by the CCS program are not covered by NEMS. Upon adequate diagnostic evidence that a Medi-Cal member under 21 years of age may have a CCS-eligible condition, NEMS MSO UM team shall refer the member to the local CCS office for determination of eligibility.

NEMS shall develop and implement written policies and procedures for identifying and referring children with CCS eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to, those which:

Ensure that NEMS's Providers perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS eligible medical condition.

Assure that contracting providers understand that CCS reimburses only CCS paneled providers and CCS-approved hospitals within NEMS network; and only from the date of referral.

Enable initial referrals of members with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or fax, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.

NEMS continues to provide all medically necessary covered services for the member's CCS eligible condition until CCS eligibility is confirmed.

Once eligibility for the CCS program is established for a member, NEMS shall continue to provide all medically necessary Covered Services that are unrelated to the CCS eligible condition and shall monitor and ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty Providers, and the local CCS program.

If the local CCS program does not approve eligibility, NEMS remains responsible for the provision of all medically necessary covered services to the member. If the local CCS program denies authorization for any service, NEMS remains responsible for obtaining the service, if it is medically necessary, and paying for the service if it has been provided.

The CCS program authorizes Medi-Cal payments to NEMS network physicians who currently are members of the CCS panel and to other providers who provided CCS-covered services to the member during the CCS-eligibility determination period who are determined to meet the CCS standards for paneling. NEMS shall inform Providers, except as noted above, that CCS reimburses only CCS paneled Providers. NEMS shall submit information to the CCS program on all providers who have provided services to a member thought to have a CCS-eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the member through an initial referral by NEMS or a NEMS network physician, via telephone, fax, or mail. In an emergency admission, NEMS or NEMS network physician shall be allowed until the next working day to inform the CCS program about the member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

10. Services for Persons with Developmental Disabilities

NEMS identifies members with developmental disabilities. The NEMS MSO Case Management team coordinates with each regional center operating within the plan's service area to assist members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution as required by W & I Code Section 14182(c)(10).

NEMS shall provide all screening, preventive, medically necessary, and therapeutic covered services to members with developmental disabilities. NEMS shall refer members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. NEMS shall monitor and coordinate all medical services with the Regional Center staff, which includes

identification of all appropriate services, including medically necessary outpatient mental health services, which need to be provided to the member.

Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered by NEMS. NEMS CM team identifies members with developmental disabilities that may meet the requirements for participation in this waiver and refers these members to the HCBS waiver program administered by the State Department of Developmental Services (DDS).

If DDS concurs with the NEMS's assessment of the member and there is available placement in the waiver program, the member will receive waiver services while enrolled in the plan. NEMS shall continue to provide all medically necessary covered services.

11. Early Intervention Services

NEMS shall develop and implement systems to identify children under 3 years of age who may be eligible to receive services from the Early Start Program and refer them to the local Early Start Program. These include children who have a developmental delay in either cognitive, communication, social, emotional, adaptive, physical, motor development, including vision and hearing, or a condition known to lead to developmental delay, or those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. NEMS shall collaborate with the local Regional Center or local Early Start Program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start Program. NEMS shall provide case management and care coordination to the member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with Primary Care Provider participation.

12. Local Education Agency Services (LEA)

LEA assessment services are services specified in 22 CCR 51360(b) and provided to students who qualify based on 22 CCR 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code Section 95020, are not covered by NEMS.

However, NEMS is responsible for providing a Primary Care Provider and all medically necessary covered services for the member and shall ensure that the member's PCP cooperates and collaborates in the development of the Individual Education Plan or the Individual Family Service Plan. NEMS shall provide case management and care coordination to the member to ensure the provision of all medically necessary diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

13. School Linked Children's Health and Disability Prevention (CHDP) Services

A. Coordination of Care

NEMS shall maintain a "medical home" and ensure the overall coordination of care and case management of members who obtain CHDP services through the local school districts or school sites.

B. Cooperative Arrangements

NEMS shall enter into one or a combination of the following arrangements with the local school district or school sites:

1) Subcontracts or other cooperative arrangements with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. The arrangements shall also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to member/student/parent on where to receive initial and follow-up services.

2) Cooperative arrangements whereby the NEMS agrees to provide or contribute staff or resources to support the provision of school linked CHDP services.

3) Referral protocols/guidelines between the NEMS and the school sites, which conduct CHDP screening only, including strategies for the NEMS to follow-up and document if services are being provided to the member, within the required State and federal time frames.

4) Any innovative approach that the NEMS may develop to assure access to CHDP services and coordination with and support for school-based health care services.

C. Subcontracts

NEMS shall ensure that the Subcontracts with the local school districts or school sites meet the requirements of Exhibit A, Attachment 6, Provision 12, regarding Subcontracts, and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination, educational responsibilities, utilization review requirements, referral procedures, medical information flows, patient information confidentiality, quality assurance interface, data reporting requirements, and Grievance and Appeal procedures.

14. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Home and Community Based Services Waiver Program

Services provided under the HIV/AIDS Home and Community Based Services Waiver are not covered under NEMS. NEMS shall maintain procedures for identifying members who may be eligible for the HIV/AIDS Home and Community Based Services Waiver Program and shall facilitate referrals of these members to the HIV/AIDS Home and Community Based Services Waiver Program. NEMS shall monitor and ensure the coordination of services with the Home and Community Based Waiver Program and continue to provide all medically necessary services to the member.

Medi-Cal beneficiaries enrolled in Medi-Cal managed care health plans who are subsequently diagnosed with HIV/AIDS, according to the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention, may participate in the HIV/AIDS Home and Community Based Services Waiver Program without having to disenroll from their Medi-Cal managed care plan. Members of Medi-Cal managed care plans must meet the eligibility requirements of the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program and enrollment is dependent on available space.

15. Dental

NEMS shall cover and ensure that dental screenings/oral health assessments for all members are included as a part of the IHA. For members under 21 years of age, NEMS is responsible for ensuring that a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. NEMS shall ensure that members are referred to appropriate Medi-Cal dental providers. NEMS shall provide medically necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, dental services that may be performed by a medical professional.

Pediatric providers shall make referrals of children to an appropriate dental provider a priority. An oral assessment is a part of CHDP screenings. Parents needing assistance with scheduling a dental appointment or obtaining transportation to the dentist shall be referred to the local CHDP office. Any referral for dental care must be documented in the member's health record.

PCPs perform dental screenings as part of the initial health assessment for all members. During an exam, a provider will assess the oral cavity and identify problems to be referred to a dentist. Assessments will include the following:

- A careful examination of the oral cavity, with retraction of the tongue to expose ventral and posterior lateral surfaces, and the floor of the mouth and bi-digital palpation for masses
- Inflamed gingiva or cyanotic gingiva
- Incompletely erupted teeth
- Pain, infection
- Tooth mobility
- Loose teeth, teeth damaged due to trauma
- Crowding or misalignment of the teeth
- Mismatching of the upper and lower dental arches
- Obvious signs of untreated tooth decay
- Retraction of gums
- Lesions on the oral mucosa
- Severe halitosis
- Obvious mouth breathing.

NEMS shall ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include contractually covered prescription drugs, laboratory services, and pre-admission physical examinations

required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure, including facility fees and anesthesia services for both inpatient and outpatient services. Effective on and after June 1, 2006, topical application of fluoride for children under 6 years of age, up to three times in a 12 month period, is a Medi-Cal Managed Care Plan benefit. When the procedure follows a protocol established by the attending physician, then nurses and other appropriate personnel may apply fluoride varnish.

NEMS requires prior authorization for medical services required in support of dental procedures.

Dental services that are exclusively provided by dental providers are not covered by NEMS. Medi-Cal members should be referred to Denti-Cal for dental services. The PCP may provide the names and numbers of specific Denti-Cal providers or the toll-free Denti-Cal phone number (1-800-322-6384) for their Medi-Cal members.

16. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

DOT is offered by LHDs and is not covered by NEMS. NEMS shall assess the risk of noncompliance with drug therapy for each member who requires placement on anti-tuberculosis drug therapy.

The following groups of individuals are at risk for non-compliance for the treatment of TB: Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin); members whose treatment has failed or who have relapsed after completing a prior regimen; children and adolescents; and, individuals who have demonstrated noncompliance (those who failed to keep office appointments). NEMS shall refer members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT.

NEMS shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance users, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers. If, in the opinion of the NEMS's Providers, a Member with one or more of these risk factors is at risk for noncompliance, the member shall be referred to the LHD for DOT.

NEMS shall provide all medically necessary covered services to the member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.

17. Women, Infants, and Children Supplemental Nutrition Program (WIC)

- WIC services are not covered under this Contract. However, NEMS shall have procedures to identify and refer eligible members for WIC services. As part of the referral process, NEMS shall provide the WIC program with a current hemoglobin or hematocrit laboratory value. NEMS shall also document the laboratory values and the referral in the member's medical record.
- NEMS, as part of its IHA of members, or, as part of the initial evaluation of pregnant members, shall refer and document the referral of pregnant, breastfeeding, or postpartum members or a

parent/guardian of a child under the age of 5 to the WIC program as mandated by 42 CFR 431.635(c).

18. Excluded Services Requiring Member Disenrollment

NEMS shall continue to cover and ensure that all medically necessary services are provided to members who must disenroll and receive major organ transplants through the Medi-Cal Fee-for-Service program until the date of disenrollment is effective.

A. Major Organ Transplants

Except for kidney transplants, major organ transplant procedures that are Medi-Cal FFS benefits are not covered under the Contract. When a member is identified as a potential major organ transplant candidate, NEMS shall refer the member to a Medi-Cal approved transplant center. If the transplant center Physician considers the member to be a suitable candidate, the NEMS shall submit a prior authorization request to either the DHCS San Francisco Medi-Cal Field Office (for adults) or the CCS Program (for children) for approval. NEMS shall initiate disenrollment of the member when all of the following has occurred: referral of the member to the organ transplant facility; the facility's evaluation has concurred that the member is a candidate for major organ transplant; and the major organ transplant is authorized by either DHCS' Medi-Cal Field Office (for adults) or the CCS Program (for children).

B. NEMS shall continue to provide all medically necessary covered services until the member has been disenrolled.

Upon the disenrollment effective date, NEMS shall ensure continuity of care by transferring all of the member's medical documentation to the transplant physician. The effective date of the disenrollment will be retroactive to the beginning of the month in which the member was approved as a major organ transplant candidate. The request for reimbursement for services in the month during which the transplant is approved are to be sent by the provider directly to the Medi-Cal FFS fiscal intermediary. The Capitation Payment for the member will be recovered from NEMS by DHCS.

C. If the member is evaluated and determined not to be a candidate for a major organ transplant or DHCS denies authorization for a transplant, the member will not be disenrolled. NEMS shall cover the cost of the evaluation performed by the Medi-Cal approved transplant center.

19. Waiver Programs

DHCS administers a number of Medi-Cal Home and Community Based Services (HCBS) Waiver programs authorized under section 1915(c) of the Social Security Act. NEMS shall have procedures in place to identify members who may benefit from the HCBS Waiver programs and refer them to the Long Term Care Division of HCBS Branch. These waiver programs include the In-Home Medical Care Waiver, the Nursing Facility Subacute Waiver, and Nursing Facility/Acute Hospital Waiver (NF/AH) and all HCBS waivers. If the agency administering the waiver program concurs with NEMS's assessment of the member and there is available placement in the waiver program, the member will receive waiver services while

enrolled with NEMS. NEMS shall continue to cover all Medically Necessary Covered Services to the member.

20. Immunization Registry Reporting

NEMS shall ensure that member-specific immunization information is periodically reported to an immunization registry(ies) established in the NEMS's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the member's IHA and all other health care visits that result in an immunization being provided. Reporting shall be in accordance with all applicable State and federal laws.

21. Erectile Dysfunction (ED) Drugs and Other ED Therapies

Erectile dysfunction drugs and other ED therapies are excluded from this Contract. These excluded drugs include all drugs used for the treatment of ED that are listed in the Medi-Cal Pharmacy Provider Manual in the Erectile Dysfunction Treatment Drug listings. The drugs listed in the Medi-Cal Pharmacy Provider Manual are not reimbursed by the Medi-Cal FFS program.

NEMS shall assist members requiring ED drugs or therapies in locating available treatment service sites and arranging for referral for appropriate services. NEMS shall continue to cover and ensure the provision of primary care and other services unrelated to the ED drugs or ED therapies and coordinate services between the Primary Care Providers and the treatment programs.

22. Vision Care

Medi-Cal health plans hold contracts with Vision Service Plan (VSP) for the provision of vision care benefits to its members. VSP provides Medi-Cal members with an eye examination, lenses, and a frame from an experienced optometrist or ophthalmologist who is a participating provider of VSP's Medi-Cal network. Members choose a doctor of their choice from a list provided by VSP. On their first visit, members should present their health plan's Medi-Cal identification card. PCPs may instruct members to check their benefit booklet for vision care benefits or instruct members to contact VSP by calling 1-800-877-7195. Members may also contact their Health Plan's Member Service Representatives for assistance.

References: CA Health & Safety Code, Sections 123800-123995; State Department of Health Services (DHCS) Agreement No. 04-36069, Exhibit A, Attachment 11, Comprehensive Case Management Including Coordination of Care Services

Policy 7: Case Management

POLICY STATEMENT

The Case Management program is a collaborative approach with the members and/or caregivers, the providers, and State and community agencies for achieving client wellness and autonomy, through advocacy, communication, education, identification of service resources and service facilitation.

OBJECTIVE

1. To define Case Management, a continuum of interventions from care coordination to complex case management.
2. To define the process by which NEMS Management Services Organization (MSO) members are identified and assessed for case management.
3. To define the process by which these members obtain access to care and services.
4. To define the Case Management staff roles.
5. To define the process by which the NEMS MSO measures member satisfaction with Case Management and incorporates this feedback into its quality improvement process.
6. To define the process by which the NEMS MSO measures effectiveness and utilizes corrective actions to improve performance and outcomes.

PROCEDURE

1. Identification of Members in Need of the Case Management Program:

NEMS MSO uses the following sources to identify members for Case Management:

a. Members identified during Utilization Management (UM) review
b. Members identified during Health Needs Assessment (HNA)
c. Member or caregiver self-referral
d. Provider referral
e. NEMS Customer Services referral
f. Claims and encounter data
g. Cost and/or Clinical Indicators
h. Seniors and Persons with Disabilities (SPD):
   - Identification as high risk by HNA. The initial screening tool administered by the Health Plan to all incoming new members that will provide supplementary information on the member's immediate and long term care needs. SPD members whose responses to the HNA indicate higher acuity health condition (e.g. homelessness, behavioral health admission, substance abuse history, frequent ER use) will be referred to Case Management. The information gathered will be used to identify risk factors to allow for a Case Manager to preserve current health status and prevent further functional decline.

2. Case Management Team:

The Case Management team consists of a Medical Director, nurses, and non-licensed care coordinators. The purpose of the team is to review complex or challenging cases and to provide multi-disciplinary input and suggestions for improvements. The Case Management team identifies modifiable risk factors or short-term interventions and coordinates continuity of care, discharge planning, and care transition. Members with complex medical and psychosocial needs will be reviewed by the Case Management team for ongoing complex case management. The Case Management team performs the following functions:

- Basic case management
- Complex case management
- Concurrent review
- Discharge planning
- Care transition
- Home visit after discharge from hospital

3. Case Management Interventions:

Case management services can be provided via phone calls or home care visits. Patients who are identified for potential case management will receive case management services via phone. Patients who are recently discharged from the hospital will receive a home visit from a Home Care Case Manager to assess their health care needs.

The NEMS MSO Case Management team will focus upon addressing immediate care needs as well as identification of modifiable risk factors that are priority areas for the member. The Case Management team supports the patient in self-management, prevention of functional decline and improving the member's quality of life through the following interventions:

a. Identifying any immediate health or medical needs, and coordinating referrals to primary care, specialty care, ancillary services, carved-out services such as behavioral health and substance abuse treatment, and maximal use of appropriate state and community resources.

b. Performing medication reconciliation by the Home Care Case Manager during home visits.

c. Assessing the member's motivation level, ability to self-manage and comprehension of the Case Management process.

d. Coaching the patient to identify a short-term achievable goal, identifying assets and barriers, using motivational interviewing techniques.

e. Promoting patient activation, adherence to primary care treatment plan and member engagement with the primary care provider.

f. Determining a schedule for follow-up with member (and caregiver, if applicable), and preferred communication method and time of day. Contacts may involve coaching calls prior to medical appointments, calls to confirm that the member kept key appointments, calls to review progress on the member's goal, and/or calls to ensure the patient is accessing needed services.

g. Developing and updating a care plan, focused on coordination of health care needs. The PCP will be contacted if there are any urgent high-risk issues, and the patient is not accessing care with their PCP.

h. Ensuring that SPD beneficiaries receive all necessary information regarding treatment and services in order to make informed choices.

i. Collaborating with the PCP to allow and ensure the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

4. Levels of Case Management:

Members identified as being at risk will be screened and categorized by Case Management staff into the following levels of case management. Dependent on further contact/assessments, the member may move from one level to another or be closed from active coordination by the Case Management program.

a. Basic Case Management: Low risk member requiring assistance with access to services, provider appointment, health coaching or health education. This level of care requires minimal interventions and interactions to support the member and their family. The member understands essential components of medical management but may need assistance to coordinate and establish appropriate health care services. Interventions may include outreaching to new members, establishing PCP care, maximizing their wellness, ongoing support to reinforce understanding of their diagnosis and symptom management, referral management or ongoing case management needs.

   Anticipated contact:

   - If member is new to Case Management services: 1-3 calls a month until transitioned to Complex Case Management

b. Care Transitions: Member is currently in an acute care facility or has been recently discharged from the hospital. Member may require services to safely transition to an alternate level of care.

   1) The Case Manager coordinates discharge planning with the hospital discharge planner as soon as possible to ensure a safe discharge from the hospital and to prevent readmission to the hospital. Case Management services may include the following:

- Evaluating the options and services required to meet the member's health and human service needs, such as the need for durable medical equipment, specialty referral, and community resources.
- Providing authorization for services as needed, such as home care services, durable medical equipment, and specialty visits.

2) For patients who are recently discharged from the hospital (excluding maternity and psychiatric discharges), a Home Care Case Manager will visit the patients at home to provide basic case management services such as assessment, medication reconciliation, PCP/specialty referral, community resources referral, and care plan formulation.

3) For patients requiring complex care after the initial home visit, the Home Care Case Manager may refer the patient to Complex Case Management. Complex cases may include, but are not limited to, patients with acute catastrophic illness or injury, severe chronic or terminal illness, inpatient length of stay over two weeks, and intensive care stay for more than 10 days.

Anticipated contact:

- An initial home visit within seven days of discharge from hospital
- Referral to Complex Case Management as needed

c. Complex Case Management: High risk members with multiple complex medical and psychosocial challenges (e.g., 3 or more emergency room visits or inpatient admits in previous 6 months; developmental disability; poverty; social isolation; poorly managed chronic diseases) AND requires multidisciplinary team planning and intervention to improve function and impact modifiable risk factors over 3 to 4 months with the goal of transferring member to primary care-based case management. This level of coordination requires maximum and aggressive interventions to support the member and their family. The member and/or family exhibits instability of medical and/or psychosocial needs which require continuous monitoring for changes in their condition. In addition, the member needs continued assistance with self-management skills.

Anticipated contact:

- 2-3 calls in the first month, 1-3 calls in the second month, then a minimum of 1 call every month until transitioned to Basic Case Management

5. Components of Case Management

NEMS MSO maintains procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the network. These services are provided through either basic or complex case management activities based on the medical needs of the member.

a. Basic case management services are provided by the PCP in collaboration with NEMS MSO and includes:

1) Initial Health Assessment (IHA)
2) Individual Health Education Behavioral Assessment (IHEBA)
3) Identification of appropriate providers and facilities to meet member care needs, such as medical, rehabilitation, and support services
4) Direct communication between the provider and member/family
5) Member and family education, including healthy lifestyle changes when warranted
6) Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies

b. Complex case management services are provided by NEMS MSO in collaboration with the PCP and includes:
    1) Basic case management services
    2) Management of acute and/or chronic illnesses, including emotional and social support issues by a multidisciplinary case management team
    3) Intense coordination of resources to ensure member regains optimal health or improved functionality
    4) With member and PCP input, development of care plans specific to individual needs and updating these care plans at least annually

6. SPD's Health Needs Assessment (HNA)

SPD members who respond to the HNA enrollment assessment will be assessed for Case Management needs based on their responses. SPD members who are identified for Case Management by alternate methods but have not completed the HNA will be enrolled in the appropriate level of case management after an initial assessment by the Case Management team.

The Case Management team ensures that SPD beneficiaries receive all necessary information regarding treatment and services in order to make informed choices.

The PCP allows and ensures the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

7. Comprehensive Baseline Assessment for Basic and Complex Case Management:

Members referred for Basic or Complex Case Management will receive a phone call from a Case Manager and will be asked if they would be willing to have a conversation about their health needs. Members who are recently discharged from the hospital will receive a home visit from a Home Care Case Manager to assess their health care needs.

The Case Manager will use the assessment tool in a patient-centered fashion, as a template to guide an interactive conversation, with the goal of identifying immediate health and care coordination needs.

Assessment responses will be documented and entered into the Case Management database. This system will serve as the data repository for patient health needs assessment,

care plan development and evaluation, communication with patients and providers, tracking of patient care progress and development of reports for NEMS MSO and the Health Plan's reporting requirements.

Members may provide telephonic approval for their designated caregiver to participate in this process.

Areas reviewed in the comprehensive baseline assessment include, but are not limited, to the following:

a. The member or caregiver's perception of his/her greatest health and medical needs and priorities.

b. Medical diagnoses and history, eliciting any chronic disease conditions, pain management, wound or ostomy care, or other high-risk conditions.

c. Patient's comfort level with self-management of illness(es) or condition(s) and ability to identify "red flags."

d. Current medications, e.g., prescribed controlled medications, over the counter medications, complementary therapies, and medications prescribed upon discharge from hospital.

e. Current and recent use of services:

- Primary and specialty care
- Dialysis, adult day health or long-term care
- Rehabilitative services history (occupational, physical, and speech therapy)
- Durable medical and adaptive equipment use and needs
- In home support services (IHSS)
- Behavioral health program
- Dental care

f. Physical function at home and in the community

g. Fall risk

h. History of intimate partner violence or other safety concerns

i. Mental and behavioral health, aiming to identify depression, cognitive function, sleep disorders, tobacco and substance abuse, and developmental delays

j. Other issues covered in the assessment:
- Chronic homelessness
- Unreliable and/or unsafe living arrangements
- Home and community safety
- History of missed medical appointments

- Social support system (formal and informal) resources
- Cultural, linguistic, and spiritual needs and preferences
- Available benefits

The assessment documentation will include the date and time of completion by Case Management staff. Paper copies of all assessments will be kept, and all assessment and care plans will be documented in the Case Management database.

8. Person-Centered Planning for SPD Members:

NEMS MSO Case Management staff and providers will provide person-centered planning that may include the following services:

a. Ensure the provision of person-centered planning and treatment approaches that are collaborative and responsive to the member's continuing health care needs.

b. Identify member's preferences and choices regarding treatments and services, and abilities.

c. Ensure the participation of the member, and any family, friends, and professionals of their choosing to participate fully in any discussion or decisions regarding treatments and services.

d. Ensure that members receive all necessary information regarding treatment and services so that they may make an informed choice.

9. Enrollment of Members into the Case Management Program

Members are given the option to enroll into the Case Management program at the time they are identified that they meet any of the criteria. They may also self-enroll at any time by contacting NEMS MSO Customer Services or through their provider.

Once a member (or the legally designated caregiver) agrees to participate voluntarily in Case Management, the Case Manager contacts the member in the language of his/her choice welcoming him/her to the program. This communication (e.g., letter or phone call) will explain the objectives of the Case Management program, the Case Management staff member's contact information, and a reminder that the member may opt out of the Case Management program at any time without any effect upon NEMS MSO benefits.

10. Case Management Process for Case Closure

The Case Management goal is to provide interventions to assist members in linking them to needed services. A Case Management case will be closed for any of the following conditions:

a. The member declines further participation.
b. The member accomplishes his or her short-term goals and no longer has need for coaching.
c. The member terminates with NEMS MSO.

d. The member expires.
e. The member is unreachable after three phone calls and has been sent an Unable to Reach Letter which includes an explanation of the Case Management Program and the NEMS MSO phone number.

Members may be extended past 90 days upon review by the Case Management team. This decision should be an exception, as the goal is to provide short-term interventions to assist members in linking them to needed services. Future longer term care management needs should be met by the PCP.

11. Measurement of Member Satisfaction with the Case Management Program

Members who participate in Case Management will be asked to complete a brief member satisfaction survey upon discharge from the program. A member satisfaction survey will be sent to the patient within 30 business days after the end of their enrollment in the program. It will assess the patient's level of satisfaction with Case Management staff as health coaches.

12. Quality Improvement Process and Ongoing Monitoring

The Utilization Management/Quality Improvement (UM/QI) Committee is the forum for oversight of the NEMS MSO's Quality Improvement and Case Management programs. This Committee meets once per quarter.

NEMS MSO maintains ongoing monitoring of the Case Management program by performing quarterly audits to ensure that case management components required by the health plans are incorporated into the program, and by soliciting feedback from providers through a semi-annual satisfaction survey. NEMS MSO also tracks unused authorizations on a quarterly basis, see UM Policy 61: Specialty Referral Tracking for details.

NEMS MSO receives CCS member lists from health plans on a scheduled basis. Case Management (CM) staff will verify a member's current case status on the CCS provider website. Active CCS members will be marked in the NEMS MSO UM system as CCS members, enabling an alert to appear and notify the UM and CM staff about a member's CCS status. UM and CM staff will follow-up with members, providers, and CCS case managers as needed to coordinate care. If available, NEMS MSO will review encounter or claims data from DHCS or the health plan to improve care coordination for members who receive carved-out services.

13. Measurement of Effectiveness of the Case Management Program

The program will be evaluated annually in terms of its impact on utilization, on process metrics outlined below, and on member satisfaction:

a. Utilization metrics:
   - Hospital bed days/1000
   - Total ER and avoidable ER visits
   - Readmission rates

b. Process metrics:
   - Total number of patients enrolled per quarter
   - Average length of stay in program
   - Average daily census (panel size for each Case Management staff)
   - Opt-out rate (total patients who decline the Case Management program over total number of patients reached by phone)
   - Turnaround time (average number of working days between Case Management referral and first patient live contact). Goal is less than five business days.

c. Satisfaction
   - Results of program satisfaction by performing provider and member surveys

Case Management Referral Criteria

Cost Indicators

- Aggregate patient claims in excess of 50% of stop loss
- DME requests greater than $2,000
- ER visits – three or more in six months
- Home IV therapy requests exceeding four weeks
- Inpatient admission length-of-stay greater than 10 days
- Inpatient admission – two or more within 30 days or three or more within 6 months

Clinical Indicators

- Cancer
- Chronic pain
- Chronic obstructive pulmonary disease (COPD)
- Congenital heart disease
- Congestive heart failure (CHF)
- Diabetes with co-morbidities
- End stage renal disease (ESRD)
- Hemophilia
- High risk pregnancy
- AIDS
- Long term injection therapy
- Morbid obesity with co-morbidities
- Multiple trauma/ head injury
- Neurological degenerative disorders (e.g., Multiple Sclerosis and Muscular Dystrophy)
- Prematurity (<32 weeks)
- TPN home therapy
- Transplants
- Ventilator dependency
- California Children Services (CCS) member – 3 months prior to 21 years of age

Case Management Sample Care Plan

Date of Referral Received: MM/DD/YYYY
Reason for CM: Referred by PCP for CM because...or ER visit 2x in 6 months....)

Reviewed clinical documentation. [NextGen, EPIC, EZ-CAP, D/C summary]

Spoke with patient on: MM/DD/YYYY
Additional Assessment: Other information that patient discloses but does not require a care plan or action to follow, such as member's comment on health status and general information. May also include member's comment on emotional and social support status if no issues reported.

Patient (Pt) agreed to CM. Involved pt in development of Person-Centered Care Plan:

Assessment: Pt does not know which is the contracted hospital and how in-network services/referrals work. Pt is not aware of NEMS's after-hours on-call physician service.
Goal #1: Pt is aware of contracted hospital and access to after-hours physician phone line for medical advice.
Intervention: Educated pt about accessing in-network services and contracted hospital. Educated and advised pt about calling PCP after-hours line for medical advice. Provided phone number and instruction to reach the operator.
Evaluation: Pt verbalized understanding, goal completed.

Assessment: Pt does not know when to return to PCP for follow-up (f/u) or was a no-show for last PCP appt.
Goal #2: Pt will see PCP as scheduled.
Interventions: Explained to pt the importance of f/u with PCP regularly for disease management. Advised pt to f/u with PCP for continued care management and as symptoms persist/worsen. Provided assigned PCP's name and contact info to pt. Reminded pt of upcoming appt with PCP.
Evaluation: Pt verbalized understanding, agreed to attend appt.

Assessment: PCP referred pt to neurology -- Pt reported she saw the neurologist on 8/24, who told her that the worsen pain is nerve pain caused by diabetic neuropathy, prescribed 2 meds (which pt cannot tell name of meds but stated that she picked the meds up already and is taking them regularly). Pt reported to f/u with the neurologist in 2 months, on 10/24, after trial of the 2 new meds.
Goal #3: Pt will follow up with the specialist as scheduled.
Interventions: Reminded pt of upcoming f/u appt with the neurologist. Reinforced importance of adherence to specialist's appt.
Evaluation: Pt verbalized understanding, agreed to attend appt.

Assessment: Pt able to verbalize most symptoms of hypoglycemia and some symptoms of hyperglycemia. Pt also able to verbalize what to do in case of hypoglycemia and stated she always carries snacks with her at all times. Pt received this information during inpatient admission and from her PCP.
Goal #4: Pt knows what symptoms manifest a hypoglycemic/hyperglycemic event and what to do in these events.

Interventions: Reinforced pt's understanding of hypo/hyperglycemia symptoms. Advised pt to watch closely for these symptoms and be prepared with snacks available at all times. Offered to mail hypo/hyperglycemia brochures. Mailing address verified, brochures sent.
Evaluation: Pt agreed to receive brochures, will f/u during next call for any questions.

Assessment: Pt would like to know more about DM management and wants a full description with insulin regimen.
Goal #5: Pt receives more teaching and assistance regarding DM management.
Interventions: Offered to mail DM brochures. Brochures regarding DM management (food choices, health education classes, DM self-management goals, ABCs of DM management, and overview of DM) sent. Provided contact information for the Diabetic Educator at NEMS clinic and explained the need for a referral from her PCP. Will relay pt's desire to see the Diabetic Educator to the PCP and also ask pt to inform PCP of her wish at the upcoming appointment on 9/5.
Evaluation: Pt agreed to receive brochures, will inform PCP for referral at upcoming appt.

Provided Nurse Case Manager's direct phone number to patient for any questions.
Next follow up scheduled on: MM/DD/YYYY

PCP is notified via NextGen/ letter (if outside PCP).

Policy 8: Case Management for Long Term Care and Skilled Nursing Facility Services

POLICY STATEMENT

1. NEMS MSO is responsible for payment for Medi-Cal members admitted to long term care (LTC) facilities for custodial care and skilled nursing facilities (SNF) for skilled care for the month of the date of admission and the following month, or until disenrollment is approved. LTC/SNF facilities include skilled nursing facilities, adult subacute facilities, pediatric subacute facilities, and intermediate care facilities.
2. NEMS MSO provides care coordination for members who are in LTC/SNF facilities, including estimating length of stay.
3. NEMS MSO member may be disenrolled from Medi-Cal managed care and receive LTC/SNF through fee-for-service Medi-Cal, if the LTC/SNF admission exceeds the month of admission and the following month. Disenrollment, if requested and approved, may become effective on the first day of the second month following the member's month of admission to a LTC/SNF facility.
4. If a member who is in a LTC/SNF facility is enrolled erroneously in the health plan, the MSO UM staff will notify the health plan for immediate disenrollment.

PROCEDURE

1. NEMS MSO case managers identify and place members in LTC/SNF facilities after an inpatient admission, or directly from the community.
2. Case mangers provide the following coordination of care services:
    - Coordinating the transfer of the member to the LTC/SNF facility
    - Notifying the member and family of the transfer to the LTC/SNF facility
    - Assuring the appropriate transfer of medical records to the LTC/SNF facility
    - Assuring that continuity of care is not interrupted
3. NEMS MSO requires medical records and a complete facesheet from the admitting LTC/SNF facility.
4. Once medical necessity review for LTC or SNF services has been reviewed prior to the admission or service, it should be reviewed at least weekly thereafter.
5. If the case manager expects the member to require LTC/SNF for a length of stay longer than the month of admission and the month following, the case manager submits a disenrollment request to the health plan. To ensure fee-for-service coverage for the third month of a stay in a LTC/SNF facility, the health plan should be notified at least thirty days in advance of the date the member is eligible for disenrollment.
6. NEMS MSO UM reviews authorization requests for medical necessity for dual eligible (Medicare and Med-Cal) members prior to SNF admission and applies the same criteria for admission as for Medi-Cal only members. Medicare covers qualified SNF admissions but does not cover LTC (custodial care). NEMS MSO covers necessary LTC. Only Medicare Certified SNFs can accept and admit dual eligible members for skilled nursing care. When Medi-Cal becomes the primary payor, NEMS MSO requires clinical documentation for medical necessity review.
7. Members who elect hospice are not disenrolled from NEMS MSO when admitted to a nursing facility regardless of length of stay.
8. NEMS MSO requires prior authorization for LTC and SNF services from the provider before the LTC or SNF date of admission. Referring providers should make referrals to

a contracted LTC or SNF provider. If a contracted LTC or SNF provider is not available, a letter of agreement (LOA) may be initiated.

9. NEMS MSO provides medically necessary care to the member until disenrollment is effective and assists with the transition to fee-for-service Medi-Cal, including the transfer of medical records.
10. Members who become eligible for Medi-Cal at the time they are in an LTC/SNF facility are not eligible to enroll in a managed care plan. If a member in an LTC/SNF facility is erroneously enrolled with NEMS MSO, the case manager notifies the health plan to request immediate disenrollment retroactive to the date of enrollment.

Definitions:

Custodial Care Services – Services and supplies furnished to a person mainly to help him or her with activities of daily life. These services are commonly for patients whose health is not expected to improve. Custodial care includes services and supplies:

1. Furnished mainly to train or assist the insured family member in personal hygiene and other activities of daily living rather than to provide therapeutic treatment.
2. That can be safely and adequately provided by persons without the technical skills of a licensed health care provider (e.g., nurse).

Disenrollment – A process by which a member who has been admitted to a SNF will be disenrolled from Medi-Cal managed care and receive SNF through fee-for-service Medi-Cal.

Intermediate Care Facility – A facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or skilled nursing facility that meets State standards and has been certified by DHCS for participation in the Medi-Cal program.

Level of Care (LOC) – The intensity of medical care provided by the physician or health care facility.

Long-Term Care (LTC) – Same as custodial care.

Medi-Medi Member – A member who has Medicare as primary and Medi-Cal as secondary insurance benefits. The term is synonymous to or also known as "dual eligible."

Pediatric Sub-acute Facility – An identifiable unit of a certified nursing facility licensed as a skilled nursing facility and meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by DHCS for such purpose. Pediatric sub-acute care is very intensive, licensed, skilled nursing care provided in Distinct-Part/Nursing Facilities Level B (DP/NF-B) in acute care hospitals, or in Free-Standing Nursing Facilities Level B (FS/NF-B) to patients under age 21 who have a fragile medical condition.

Skilled Nursing Facility – Any institution, place, building, or agency licensed as a skilled nursing facility by DHCS or is a distinct part of a hospital that meets State standards (distinct parts of hospitals do not need to be licensed as a skilled nursing facility) and has been certified by DHCS for participation in the Medi-Cal program.

Skilled nursing care consists of services that must be performed by a registered nurse or licensed practical (vocational) nurse. Skilled nursing service is not custodial in nature; it is a service reasonable and necessary for the treatment of an illness or injury. These services may be occupational therapy, physical therapy, and speech therapy and should "improve the member's health."

Sub-acute Facility – An identifiable unit of a skilled nursing facility accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by DHCS for such purpose. Sub-acute care is care needed by a patient who does not require hospital acute care, but who requires more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility. Sub-acute patients are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care.

Policy 9: Cervical Cancer Screening

NEMS MSO provides coverage for an annual cervical cancer screening test upon the referral of the patient's physician or nurse practitioner. The coverage includes the conventional Pap smear and the option of any cervical cancer screening test approved by the federal Food and Drug Administration (FDA).

Cervical cancer screening procedures that can be performed at the NEMS MSO provider's office do not require prior authorization, e.g., Pap smears. However, prior authorization is required if the NEMS MSO provider plans to refer the patient to an outside provider for the screening. The NEMS MSO provider submits the request for authorization form to the Utilization Management department for review. If the criteria are met, the request will be approved and the provider informed. If the criteria are not met, the request will be denied. The provider will be notified of the denial and sent a denial letter explaining the reason for denial and the appeal process (see policies and procedures on referral authorization).

Policy 10: Child Health and Disability Prevention Program (CHDP)

POLICY

CHDP is a preventive program that delivers periodic health assessments to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts via school nurses. All Medi-Cal recipients from birth to age 21 are eligible for CHDP scheduled periodic health assessments and services based on the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. CHDP provides a schedule of periodic health services to non-Medi-Cal children and youth from birth to age 19 years whose family income is equal to or less than 266 percent of the federal income guidelines. All children and youth are eligible for health assessments based on the same schedule or periodicity used for Medi-Cal children and youth.

PROCEDURE

NEMS MSO identifies eligible contracted CHDP providers through the credentialing process and maintains a roster of primary care providers (PCPs) and their enrollment status with CHDP. Eligible CHDP providers can be found at the following website:

- **Website:** https://www.dhcs.ca.gov/services/chdp/Pages/ProgramOverview.aspx
- **Provider List:** Each county maintains their own lists. Contact local county offices.
- **Contact for Local County Offices:** https://www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx

Participating PCPs are responsible to ensure services are provided in accordance with the most current CHDP standards.

Covered Services and Benefits

Periodic Child Health Assessments/Examinations

NEMS MSO follows the periodicity for well child health assessments for Medi-Cal Managed Care members in accordance with the Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule. Participating CHDP providers conduct age-appropriate assessments at the time of the Initial Health Assessment (IHA). Services during initial and periodic health assessments include:

- Age-appropriate Individual Health Evaluation Behavioral Assessment (IHEBA)
- Health and developmental history
- Complete physical examination
- Oral health assessment
- Nutrition assessment
- Behavioral assessment
- All immunizations to ensure that the member is up-to-date for age, according to the Advisory Committee on Immunization Practices (ACIP) immunization schedules.

- Vision and hearing screenings Laboratory tests for anemia, blood lead, tuberculosis, urine abnormalities, sexually transmitted diseases, and other problems as needed.Health education and anticipatory guidance.

PCPs must document the following elements in the member's health record to monitor and improve utilization of CHDP services, including follow up, to ensure services are provided:

- Screening services provided and their results
- Referral for diagnosis and treatment
- If necessary, justification for any delays beyond sixty days for the initiation of diagnosis/treatment
- Results of diagnosis and treatment services
- Documentation of attempts to reach member and referrals to medical group and/or Health Plan's case managers
- Encounter reporting
- When appropriate, documentation of member or parent/guardian refusal of CHDP services

PCPs may also authorize the school district to perform CHDP assessments for health plan members. If the member fails to show up for more than two (2) visits with his/her PCP for CHDP assessment, or the PCP is unable to provide an assessment within sixty (60) days of the school district referral, then the school district is authorized to perform a CHDP assessment.

Treatment and Referrals

At the time of the health assessment, CHDP providers make referrals to:

- Women's, Infant and Children (WIC) Nutrition Program for children up to age 5
- Dentists for preventive or restorative care
- Medical specialists as necessary
- Mental health providers as necessary
- Any of the following programs as necessary: California Children's Services (CCS), Regional Center, Early Start/Early Intervention, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Members with significant health problems are diagnosed and treated by the PCP, or if appropriate, referred for diagnosis and treatment. Diagnosis and treatment for conditions detected at the time of assessment must be initiated within 60 days of the assessment.

Care Coordination

CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

School Entry Health Exam Requirement

CHDP works with schools to meet the requirement of having a completed health assessment 18 months before or up to 90 days after enrolling in first grade. The CHDP program assists families to meet the requirement by linking families with CHDP providers to obtain health assessments. The certificate "Report of Health Examination for School Entry" is available through the local CHDP program, schools, and provider offices.

Member Notification of CHDP Services

Medi-Cal members under the age of 21 will be advised at each non-emergent PCP encounter of available CHDP services. Medi-Cal members who have not received all of the CHDP services will receive information from the provider on how to access these services. The provider will share results of the CHDP health assessment with the member and/or parent/guardian within one month of the assessment. Discussion or consultation regarding the results of the assessment will be provided by the provider, as appropriate, upon the member or parent/guardian's request.

Disenrollment/Loss of Eligibility

There may be instances where a Medi-Cal member may disenroll or become ineligible for .Medi-Cal. If the child/youth has been scheduled for or has begun the CHDP health assessment process, the PCP may continue to provide care through. CHDP if he/she is from birth to age 19 years and his/her family income is equal to or less than 266 percent of the federal income guidelines. The PCP must be enrolled as a CHDP provider through the local CHDP office. If the PCP is not an enrolled CHDP provider, the member must be referred to the local CHDP Program to receive assistance in accessing a certified CHDP provider.

Policy 11: Comprehensive Perinatal Services Program (CPSP)

POLICY

Comprehensive Perinatal Services Program (CPSP) is a state funded program run by the California Department of Public Health, that seeks to improve the health of low-income pregnant women and to give their babies a healthy start in life by providing enhanced Medi-Cal reimbursements to CPSP-certified obstetrical providers who implement CPSP protocols in their practices. The goals of CPSP are to encourage early and continuous prenatal care, decrease incidences of low-birth weight infants, improve outcomes of every pregnancy, and lower health care costs by preventing catastrophic and chronic illness in infants and children. CPSP provides obstetric, psychosocial, nutrition, and health education services, and related case coordination to all Medi-Cal pregnant women from conception through 60 days post-partum. CPSP is provided to all NEMS MSO pregnant members by our Board-Certified Obstetricians.

PROCEDURE

All NEMS MSO obstetricians offer pregnant women CPSP services and refer patients with high-risk pregnancies to appropriate specialists, including perinatologists, and provide access to genetic screening with appropriate referrals.

If the pregnant woman declines CPSP services, NEMS MSO providers have the woman sign an Acknowledgement Form stating they were offered services and declined. Participation in CPSP is voluntary. The Acknowledgement Form is retained in the woman's file/chart.

The MSO UM/QI Committee reviews appropriate utilization of CPSP practitioners annually.

All NEMS MSO providers (regardless of CPSP certification) must utilize CPSP tools, including a comprehensive risk assessment tool that is comparable to ACOG, and CPSP standards to document Prenatal and Postpartum Care. The forms can be obtained from the NEMS intranet (Sharepoint) or from the following website: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/pages/default.aspx

The NEMS clinic maintains a Prenatal Log which identifies pregnant women and offers CPSP services. High risk pregnancies are recorded in the log and tracked for referral services to perinatology and genetic screening.

Perinatal Care

Pregnancy tests are available to all members from either the PCP or through family planning providers without prior authorization. Members may seek prenatal care from an obstetrical provider within NEMS MSO without prior authorization. The member will be delivered at the hospital with which her PCP and Obstetric Provider are affiliated. The Obstetrician coordinates with the PCP to provide the member with necessary specialty care.

All pregnant women undergo a risk assessment according to CPSP guidelines at the initiation of care and during reassessments each trimester and in the postpartum period.

The Obstetricians complete the Psychosocial, Health Education, and Nutrition Initial and Trimester Assessment forms which are submitted with the claims forms.

Initial Prenatal Evaluation

Members are offered CPSP Services at the time of the initial OB visit. The initial prenatal evaluation consists of:

- Comprehensive health history with information on menstrual history, family planning methods used, detailed history of past pregnancies and outcomes, drug sensitivities and allergies
- Data on current pregnancy to assist physician in estimating date of delivery
- Family and social history
- Physical examination to evaluate patient's current condition including height, weight, blood pressure, breast exam, abdominal exam, and external and internal genitalia evaluation as appropriate
- Prenatal panel may include: CBC, Hemoglobin Electrophoresis if MCV <80, urinalysis, urine culture if indicated, HBsAg, HBsAb, HBcAb, hepatic function panel if indicated, HIV-1 Antibody, RPR & MHA-TP if indicated, Rubella IgG, ABO & Rh type and antibody screening
- TB screening (QFT)
- Expanded alpha-fetoprotein screen (gestationally appropriate)
- Prescription for prenatal vitamins
- Assessment of nutritional, education, and psychosocial risk factors, with the development of an individualized care plan, and interventions as appropriate
- Assessment to identify risk factors that may require special management

The Obstetrician will record the results of the patient's initial evaluation on the prenatal medical record form.

Reassessment

Visits for an uncomplicated pregnancy will include an exam every 4 weeks for the first 28 weeks of pregnancy, every 2 to 3 weeks until 36 weeks of gestation, and weekly thereafter. Women with active medical or obstetric problems will be seen more frequently, at intervals determined by the nature and severity of their medical problems.

Follow-up visits include:

- Opportunity for a member to ask questions about pregnancy and comment on self-perceived changes since the last visit
- Health promotion and maintenance education, including discussion of activities to promote health, such as adequate exercise and abstinence from tobacco, alcohol, and drug use
- Documented informing member of NEMS MSO coverage of 48 hours of hospital stay following a vaginal delivery and 96 hours following a delivery by cesarean section, for the member and her newborn

- Physical exam includes blood pressure and weight, fundal height, fetal heart rate, and fetal presentation
- Urinalysis for albumin and glucose
- Risk factors/changes/assessment for spousal abuse
- Visit during the third trimester also includes: Hgb/Hct and glucose screenings for women greater than 30 years old, or deemed necessary by the prenatal provider
- For high-risk women, repeat STD screening (including HIV with appropriate counseling and/or toxicology screening
- For unsensitized Rh negative women, repeat Ab test at 28 weeks and if indicated, give prophylactic Rho (d) immunoglobulin
- Give information on what to do if labor begins, membranes rupture or bleeding occurs
- Discuss delivery analgesic/anesthetic options, and review plan for hospital admission, labor, and delivery

Postpartum Assessment

Postpartum examination is performed between 4-8 weeks after normal delivery and 2 weeks after C-section. The first postpartum review includes an interval history and physical exam to evaluate patient's current condition and includes weight, blood pressure, breast exam, abdominal exam, external and internal genitalia evaluation. Laboratory tests are ordered as necessary.

The postpartum visit will also include assessment of nutritional, education, and psychosocial risk factors, with the development of a care plan and interventions as appropriate. Evaluation will include review for family planning requirements, immunizations (including rubella) if appropriate, special problems and return to work status.

The Obstetrician will encourage the establishment of ongoing well care for the mother, including gynecological/family planning services within the NEMS MSO network and reinforce the need for pediatric well child care for her newborn.

Interdisciplinary Prenatal Assessments

All pregnant Medi-Cal members receive comprehensive prenatal services. Based on the need of the member, she may be referred to nutrition counseling, psychosocial evaluation and support, general prenatal/postpartum education classes, Women, Infants, and Children (WIC), genetic screening, dental care, family planning, CHDP, community resources, etc. CPSP services are provided by the following practitioners:

- Primary Care Physician makes referral to Obstetricians and coordinate care with OB for specialty care
- Obstetrician is the main provider for the care of the pregnant woman
- Pediatrician may meet with expecting mothers to explain pediatric care
- Nurse Practitioners may provide care with the supervision of a physician
- Case Manager coordinates member needs
- Registered Nurse may interview and provide care in his/her scope of practice
- Licensed Vocational Nurse may provide care in his/her scope of practice
- Mental/behavioral health providers address the member's mental health needs

- Health Educator may provide health education
- Nutritionist educates the member about dietary needs

An initial assessment including psychosocial, nutritional, and health education is required upon entry to care. Complete reassessments, including all the above elements, are to take place during the second trimester (14-24 weeks), third trimester (25-36 weeks) and postpartum period (4-8 weeks after delivery).

All visits, consultations, referrals, etc., are documented in the member's medical records.

Individualized Care Plan

Individualized care plans are developed for each member and include obstetrical, nutrition, psychosocial, and health education interventions when indicated by identified risk factors. Care plans, referrals, follow-up plans and outcomes are documented in member's medical records. Referral to the local WIC special supplemental nutrition program will be made when appropriate.

A primary case manager is identified for each prenatal patient and the case manager's name is documented on the care plan. In cases where providers do not have access to the expertise to address a member's needs, the NEMS MSO Case Management Department will assist with linkage. For complex needs, the NEMS MSO Case Manager will co-manage with the health plan's Case Manager.

Tracking

The Medical Referral Assistant is responsible for tracking referrals to specialists to ensure that a consultation is completed. After a referral is made by the PCP or the OB, the Medical Referral Assistant will track the consultation report and contact the specialist for consultation status. The patient's PCP or Obstetrician will be notified of the consultation status.

The patient's Case Manager is also responsible for coordinating the needs of the patient. The Case Manager will ensure that the patient receives the care needed and that the patient keeps the medical appointments.

Educate providers

The CPSP program is outlined in the Provider Manual and is available to all providers. In addition, the perinatal program is explained to new providers during orientation.

Standards

Members with high obstetrical risk should be referred for evaluation and care if it is beyond the scope of practice of the initial prenatal provider. High risk indicators or markers include:

<u>Medical Problems</u>

- Cardiovascular, renal, collagen, pulmonary, infectious, hepatic, and sexually transmitted disease

- Metabolic or endocrine disorders
- Chronic urinary tract infections
- Maternal viral, bacterial, or protozoal infections
- Diabetes mellitus
- Severe anemia
- Isoimmune thrombocytopenia
- Seizure/neurologic disorders
- Substance abuse (e.g., alcohol, tobacco, illicit drugs, prescribed medications)
- Nutritional disorders, hyperemesis, anorexia

Obstetric/Genetic Problems

- Poor obstetric history
- Maternal age under 16 or over 35 years
- Previous congenital anomalies
- Multiple gestation
- Isoimmunization
- Intrauterine growth retardation
- Third-trimester bleeding
- Pregnancy-induced hypertension
- Uterine structural anomalies (e.g., septum, other abnormalities)
- Abnormal amniotic fluid volume (hydramnios, oligohydramnios)
- Fetal cardiac arrhythmias
- Previous preterm birth
- Birth defects or genetic conditions in the fetus
- Breech or transverse lie (intrapartum)
- Rupture of membranes for a period longer than 24 hours
- Chorioamnionitis

Members may be referred by the initial prenatal care provider to the following network practitioners when high risk prenatal care is indicated. Providers can contact NEMS MSO Provider Relations Department for a list of specialists, if needed.

- Genetic counselors
- Tertiary ultra-sonographers
- Perinatologists
- Pediatricians and neonatologists for intensive newborn care and high-risk follow-up

Members identified to be at high risk due to co-morbid conditions, including substance abuse and/or complicated psychosocial needs (including psychiatric or emotional problems), shall be followed and case managed by NEMS MSO.

Genetic Screening and Counseling

Antenatal screening will be done whenever indicated to identify possible risks prior to pregnancy. Couples who have increased risks for producing an abnormal offspring will be offered the opportunity to undergo prenatal diagnostic studies after appropriate counseling.

Prenatal care providers will refer members for pre-pregnancy genetic counseling if indicated due to a member's family history of congenital abnormalities, previous congenital abnormalities or current use of medications contraindicated in pregnancy.

Genetic testing referrals will be reviewed for benefit coverage and medical necessity. If the genetic testing is a Medi-Cal covered benefit and the member meets the medical necessity criteria, the referral will be made to a tertiary medical center in NEMS MSO network. Referrals will be made in a timely manner to enable the woman to consider the option of abortion or adoption/foster care if she desires. Families will be counseled regarding risks and benefits of screening, types of screening, and types of available termination depending on gestational age. Referrals of pregnant women to a geneticist will be made, but not limited to, the genetic risk factors listed below:

- Advanced parental age (mother 35 years of age or older at the expected date of delivery)
- Previous offspring with a chromosomal aberration, particularly autosomal trisomy
- Chromosomal abnormality in either parent, particularly a translocation
- Family history of a sex-linked condition
- Inborn errors of metabolism
- Neural tube defects
- Hemoglobinopathies
- Ancestry indication risk for Tay-Sachs, beta-thalassemia, or alpha-thalassemia

The following invasive diagnostic procedures may be used:

- Amniocentesis
- Chorionic villi sampling
- Percutaneous umbilical cord blood sampling
- Intra-uterine fetal biopsy
- Parental testing if at high risk for a genetic disorder

The member's obstetrical provider is responsible for identifying members at risk, offering genetic counseling and testing, and if the member refuses, documenting the refusal.

Specific cases not addressed by protocol shall be subject to prior authorization. In these cases, the obstetrician is responsible for requesting prior authorization approval.

Sterilization Consent

Human Reproductive Sterilization is defined as "any medical, treatment, procedure or operation for the purposes of rendering an individual permanently incapable of reproducing."

Prior to sterilization, the member's provider determines the member is:

- 21 years of age or older
- Mentally competent to give written consent
- Not currently institutionalized
- Able to understand the content and nature of the informed consent process
- Voluntarily giving informed consent

The informed consent process is conducted either by the physician or the physician designee and includes:

- Ensuring the member has time to ask questions regarding the procedure
- Providing the member with a copy of the consent form
- A thorough explanation of the procedure, length of hospitalization, and any risks or side effects associated with the procedure
- Advice that the procedure is considered to be irreversible
- Advice that the procedure will not be performed for at least thirty (30) days unless the member has waived in favor of a 72 hour waiting period
- The name of the physician performing the procedure
- Advice to the individual that consent for the procedure can be withdrawn at any time before the sterilization without affecting the right to future care or treatment

The physician will:

- Use the State of California Health and Welfare consent form (PM330) and ensure the form is properly completed and signed
- Ensure the consent is signed at least thirty (30) days, but no more than one hundred eighty (180) days, before the sterilization procedure
- Document the informed consent process on the medical record and include the signed consent form in the medical record
- Forward a copy of the consent form to NEMS MSO

Reporting/Tracking

Perinatal care visits and services rendered to health plan members are to be reported using HCFA 1500 forms, using the appropriate CPT, HCPCS and/or Medi-Ca codes. All maternity services must be reported on an itemized basis. Claims for all CPSP services should be submitted using CPSP-specific procedure codes.

Reference:
Website: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

Policy 12: Confidentiality Policy

PURPOSE:

NEMS MSO will safeguard all patients' individually identifiable health information and protect patient's privacy rights in accordance with state and federal laws and regulations. We will accomplish this in ways that are reasonable and consistent with sound business practices. Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

- Is created or received by a health care provider, clinic, employer and
- Relates to past, present, or future physical or mental health or condition of an individual; or, the past, present or future payment for the provision of health care to an individual; and
    - That identifies the individual; or

- With respect to which there is reasonable basis to believe the information can be used to identify the individual.

POLICY:

Preserving the confidentiality and security of patient information is a basic tenet of NEMS, as well as a requirement by law. Patients must be able to rely on the confidentiality of provider-patient communications, test results, medical histories, etc. Any unauthorized disclosure of medical information or individually identifiable information is prohibited and will be grounds for disciplinary action, up to and including dismissal from the organization.

GUIDELINES FOR EMPLOYEES, VOLUNTEERS AND VISITORS:

NEMS' guidelines regarding patient confidentiality apply to all NEMS workforce in all areas of the organization. Workforce includes employees, volunteers, and visitors. For specific information concerning patients' medical records, the Health Information Services (HIS)/Medical RecordsDepartment Policies and Procedures should be consulted. Each employee, volunteer and visitor will sign a confidentiality statement. Any employee, volunteer and visitor who violates our privacy policy is subject to a disciplinary process. Employee, volunteer, and visitor access to privacy information is limited to a "need to know basis." In compliance with state and federal laws to implement appropriate technical and physical safeguards to protect unauthorized access, the following restricted access applies:

- The HIS/Medical Records Department is a RESTRICTED AREA. Only authorized staff may enter.
- Provider offices are RESTRICTED AREAS. Non-staff members including vendors, visitors, or friends of staff should have limited access to patient care areas.
- Computer screens in patient areas have privacy filters and are not visible to non-employees
- All computers are password protected.

1. CONFIDENTIALITY OF PATIENT INFORMATION

Patient information, whether in the form of the documentary medical record, electronic (computerized) data including digital images, or as information known to a member of the staff, is strictly confidential and may be disclosed only when required for treatment by those who are responsible for the patient's care, for payment, or to conduct necessary health care operation. Each employee, volunteer and visitor who request information must have a legitimate reason that has been established by NEMS policy. NEMS providers and staff shall have access to patient information on a need-to-know basis, and clinicians may abstract patient information for consultants to whom they refer patients. Clinic nurses will obtain patient consent if a consultant is not a contracted provider. Other health care providers outside of NEMS shall have access to patient information upon receipt of a properly executed written authorization by the patient or his or her legal representative. Procedures for responding to other types of requests for information are stated in the HIS/Medical Records Department Policies and Procedures.

Confidentiality also applies to medical information about fellow employees and co-workers. This confidentiality applies to any information that is learned during the course of employment at NEMS.

The documents that constitute a patient's medical record are the property of NEMS, but the patient has the right to request to access, amend, or restrict disclosure according to NEMS policy. The original documents may not be removed from any site, except in accordance with a specific written authorization of Administration, or in the case of legal process, such as, a subpoena or court order, and then only if a copy of the medical record will not be sufficient. Medical records shall be examined or reviewed within the site, rendering the records accessible to appropriate staff Portable storage drives and devices are banned from use by NEMS Policy and Active Directory Group Policy. These devices will not function when attached to any computer at NEMS. The electronic health record (EHR) may be accessed remotely on a restricted basis for providers only, in accordance with NEMS Remote Access Policy.

All new employees will receive an orientation including Privacy and Confidential Training and will sign a confidentiality statement. All volunteers and visitors will need to read "NEMS HIPAA/Confidentiality Policy" and then sign the confidentiality statement. The All staff will conduct annual confidentiality training and will sign a confidentiality statement.

All documents containing patient information are protected either by limiting access or by appropriate destruction in accordance with NEMS policies. Copies of lab results, appointment schedules, patient bills, etc, which are no longer needed, will be placed into the bins marked for confidential shredding and destroyed by an authorized third-party service.

2. CONFIDENTIALITY OF NON-MEDICAL INFORMATION

Personnel, payroll, billing, insurance, and demographic information containing any individually identifiable health information, including address, phone number, social security number, email address and date of birth, are also considered confidential and are covered by this policy.

3. CONFIDENTIALITY OF PATIENT RELATED DISCUSSION

The need to protect the privacy of a patient's medical information also applies to verbal discussions. It is easy for persons to overhear conversations in public areas. Even a seemingly harmless remark overheard by another person can be embarrassing or damaging to a patient. All NEMS personnel should take care to conduct such discussions in a way that protects the patient's privacy.

It is never appropriate to discuss confidential patient information outside of NEMS with family and friends.

4. RELEASE OF INFORMATION

All requests for release of patient information including requests for copies of a patient's medical record are to be referred to the HIS/Medical Records Department. Requests for patient information at any of the NEMS sites shall be processed by the HIS/Medical Record Department in accordance with the HIS/Medical Records Release of Information Policy and Procedure.. An Authorization to Disclose Health Information Form must be completed and signed by the patient/parent or guardian.

A general authorization for the release of medical or non-medical information is NOT sufficient to release sensitive information. This includes information regarding mental health, drug and alcohol use, sexually transmitted diseases (STD), sexual orientation, sexual assault, HIV test results, and information about a minor regarding family planning, STDs, psychosocial, and alcohol or drug abuse history. For more information about the release of sensitive information, consult the HIS/Medical Records Department. To protect and maintain the confidentiality of psychotherapy records our policy includes:

- Description of the process that ensures no person or entity can obtain medical information related to a patient's outpatient treatment by a psychotherapist without making a written request to the treating provider and providing written notice to the patient.
- The written request must be signed by the requestor, identify what information is requested, state the purpose of the request, indicate the length of time the information will be kept, include a statement that the information will not be used for any purpose other than its intended use, and a statement that the requestor will destroy the information when it is no longer needed.
- Specifics on how the documents are to be destroyed.
- Specifics regarding faxing and copying these highly sensitive records.

We maintain written contracts with third parties to help ensure that the personal information we share is used for legitimate business purpose.

5. COMPUTER SYSTEMS SECURITY

Information system security measures include user passwords, data encryption, and protection of all computer data information. Users logged onto computers or terminals shall not leave them unattended without exiting the system or invoking password-protected security features nor shall users allow others to access or edit information under the user's password. The system automatically logs users out if unattended for five minutes. In addition, passwords shall not be disclosed or shared with other employees. If at any time a staff member suspects that another person knows his/her password, the Information Technology (IT) Department should be contacted to assist to change the password or cancel the compromised password and obtain a new one. The IT Department will maintain and oversee the use of electronic protected health information by periodically checking the audit trail ensuring only appropriate staff has accessed confidential information. Protected health information (PHI) must be sent by secure email.

6. FACSIMILE (FAX) TRANSMISSION OF CONFIDENTIAL MATERIAL

In situations where transmission via fax is necessary, the staff that transmits via fax shall be responsible for ascertaining to the best of their ability that the receiving machine is in a secure location and that the confidentiality of the material can be preserved. Refer to the NEMS policy on faxing for further details.

7. PENALTY FOR RELEASE OF CONFIDENTIAL INFORMATION WITHOUT AUTHORIZATION

NEMS employees, volunteers and visitors are required to comply with all policies and procedures to protect the confidentiality of the patient's individually identifiable information. A staff member of NEMS may be disciplined and may in appropriate cases be discharged for the release of confidential information to an unauthorized person or organization.

8. PENALTY FOR UNAUTHORIZED ACCESS OF INFORMATION

Unauthorized access of PHI by NEMS staff will be reported to the NEMS Privacy Officer. Necessary action will be taken, including sanctions and/or reporting the violation to state and federal agencies. Any workforce member of NEMS may be disciplined and may in appropriate cases be discharged for unauthorized or unnecessary access or retrieval of confidential patient information regardless of whether disclosure is made to others. Access to patient information may be made only on a need-to-know basis, in order to conduct authorized business.

If you access Protected Health Information (PHI) or Personally Identifiable Information (PII), you are personally responsible for ensuring the confidentiality, privacy, and security of the data entrusted to you, and you could be personally subject to statutory fines and penalties for failure to comply.

Policy 13: Continuity of Care and Out-of-Network Services

Policy

1) The UM team reviews requests for out-of-network (OON) services to determine if services can be done in-network
2) Members may be eligible for continuity of care with a terminated provider or non-contracted provider if they meet the conditions listed in this policy
3) The UM team coordinates in-network services for the member when OON requests are denied
4) NEMS MSO tracks and monitors services denied for OON to ensure appropriateness of denial

Procedure

Requests for OON services are reviewed to determine whether the services can be provided in-network. The UM team reviews the following items:
1) Availability of In-network Providers:
   a. The UMC checks the contracted provider list to assess whether in-network providers are available
   b. The UMC assesses whether the in-network provider is agreeable to treating patient's specific condition
   c. The UMC ensures that the in-network provider is available to treat the patient within a reasonable timeframe based on urgency of patient's medical needs

2) Continuity of Care
   a. Current Member Continuity of Care

If a member is receiving care from a provider whose contract with NEMS MSO terminates while the member is under treatment, NEMS MSO will authorize medically necessary and appropriate treatment by that provider for up to 12 months. Members may be eligible for continuity of care with a terminated provider if they are being treated for the following conditions:

- Treatment for acute conditions. The provider shall provide the completion of covered services for the duration of the acute condition.
- For members who are undergoing a course of treatment for a serious chronic condition. The provider shall provide the completion of covered services
    - For a period of time necessary to complete a course of treatment and to arrange for a safe transfer to a NEMS MSO provider, as determined by NEMS MSO in consultation with the member and the terminated provider and consistent with good professional practice; or
    - Not to exceed twelve (12) months from the date of the provider contract termination
- Pregnancy (including all three trimesters and post-partum care)
- Terminal illness, provider shall provide the completion of covered services through the duration of the terminal illness.
- A child between birth and 36 months. Completion of covered services shall not exceed 12 months from the effective date of coverage

- A surgery or other procedure that has been authorized by NEMS MSO and documented to occur within 180 days of the contract termination or within 180 days of the effective coverage under the health plan

b. New Member Continuity of Care

While the health plan requires that covered services be obtained from contracted providers of the medical group, if a newly enrolled member is being treated for an acute condition by a non-contracted provider, then to the limited extent required by state law, the newly enrolled member may enroll with the health plan and continue to receive treatment from the non-contracted provider. A member may request continued care from a provider, including a hospital, if at the time of enrollment, the member was receiving care from a non-contracted provider for any of the following conditions:

- Treatment for acute conditions
- Serious chronic conditions for up to 12 months from the effective date of coverage
- Pregnancy, except during the first and second trimester periods, but including immediate post-partum period
- A newborn child, in the first 30 days, under mother's enrollment
- A terminal illness for the duration of the terminal illness, on a case-by-case basis
- A surgery or other procedure that has been authorized by NEMS MSO and documented to occur within 180 days of the contract termination or within 180 days of the effective coverage under the health plan

NEMS MSO provides authorization for continuity of care under the following circumstances:

- The care from the non-contracted provider would not be covered by any other health plan offered to the member
- The services for the acute condition are otherwise covered services under the Evidence of Coverage when provided by medical group providers
- When timely access of care with in-network providers is not met

NEMS MSO is not required to provide coverage if:

- The non-contracted provider does not accept the same contract terms/Medi-Cal rates of participating providers
- The services are not otherwise covered by the health plan
- The new member was offered a comparable in-network option
- The new member had the option to continue with a previous plan and voluntarily chose to change plans

3. Care Coordination Services

NEMS MSO UMC assists member in transitioning to in-network provider. The UMC explains to member about in-network services, better coordination of care among providers in the same network, and assists the member in setting up an appointment with an in-network provider. The following members will be contacted by the UMC for care coordination:

- Members whose services are denied due to medical necessity or administrative denials (e.g., non-covered benefits, out-of-network services) – Cases are identified by a daily system auto-generated report. UMC contacts the member and directs member to in-network providers

The following members may require more extensive coordination of services. The UMC will refer the case to the case management (CM) team where CM team members will provide case management services:

- Members who need coordination of care for multiple out-of-network specialties
- Members who need to continue with out-of-network care based on medical necessity
- Members who need coordination of care between in-network and out-of-network providers

4. The UM Manager reviews the appropriateness of out-of-network denials on an ongoing basis. In addition, the QI team audits denial files during the Interrater Reliability Studies annually.

Policy 14: Continuity of Care – Transition Assistance

POLICY

NEMS MSO tracks and monitors authorization and service utilization to identify members who may need transition assistance due to changes in their medical benefits. NEMS MSO Case Management provides care coordination for members whose benefits ended, to ensure members continue to receive timely access to appropriate care and services.

PROCEDURE

A. Care Coordination for Notice of Action Letters

NEMS MSO issues denial for out-of-network prior authorization requests if the services requested are available in-network. Notice of Action (NOA) letters are sent for all denied requests. The procedure is as follows:

1. The UMC reviews and processes the prior authorization request
2. If the out-of-network request is available in-network, and the request is not continuity of care, then the request is denied
3. The NOA letter is sent to the member within 3 calendar days of the decision
4. The UMC refers the case to a Case Management Care Coordinator to outreach to the member and PCP office to obtain a new referral
5. The Care Coordinator follows up with PCP office and UM Department to ensure that a new prior authorization is processed for the member
6. The Care Coordinator follows up with the member to assist in transitioning care to the in-network provider
7. The Care Coordinator remains as a resource for the member should there be any issues in obtaining the necessary services

B. Care Coordination for Members Whose Benefits End

NEMS MSO Case Management identifies members whose benefits end, e.g., when a member's managed care Medi-Cal benefit is going to end or when a member is going to age out of the California Children's Services (CCS) program at the age of 21 and transition to Medi-Cal coverage.

1. NEMS Case Management identifies members whose benefits will end via reports and referrals from the Health Plan
2. The Care Coordinator will outreach to members as soon as they are aware that the managed care Medi-Cal benefit will end. The Care Coordinator coordinates care with the PCP, existing specialists, member, and family to ensure care is transitioned to the new insurance. If the member does not have alternative health insurance, the care coordinator works with a NEMS or community social worker to search for alternative resources for the member.
3. For CCS members who are about to age out, the Care Coordinator coordinates care with the PCP, specialist, member, and family at least two months before the member reaches their 21st birthday and explain to the member about the age-out process. The Care Coordinator will assist the member in establishing care with an adult PCP and obtain referrals for specialty care as needed
4. The Care Coordinator will work with the UM Department to ensure prior authorizations are processed in a timely manner

5. Members will be informed how to reach the Case Management team for any access-related issues in the future
6. For CCS members with complex medical needs, the NEMS Nurse Case Manager will continue to provide complex case management services

In addition, NEMS MSO identifies members whose Kaiser benefits have ended to assist these members in transitioning care to Medi-Cal coverage.

1. NEMS Case Management identifies members who accessed Kaiser services to determine whether assistance is needed to establish care with their Medi-Cal primary care providers
2. The Care Coordinator outreaches to members to explain Medi-Cal insurance coverage and benefits, and if needed, assists the member in establishing care with a PCP
3. In the case that a member desires to change the medical group, the Care Coordinator will connect the member with the Health Plan Customer Service representative for further assistance

C. Documentation of Care Coordination Activities

Care coordination activities that are provided for members whose benefits end or for members who receive a NOA letter are documented in the EZCARE system.

Policy 15: Coordination of Care

POLICY

1. NEMS MSO assures coordination of care for members who are referred by their primary care provider (PCP) for in or out-of-network services, including ambulatory care, hospitalization, and emergency services.

2. NEMS MSO ensures access to care and services for members receiving treatment for acute and/or chronic conditions.

PROCEDURE

Care coordination includes services to implement the member's care plan and begins once the care plan is initiated. Care coordination may include periodic case conferences in order to ensure that the member's care is continuous and integrated among all service providers.

To deliver intensive care coordination services, the NEMS Care Team staff maintain frequent, in-person contact with the enrollees. The Nurse Case Manager (NCM) and Case Management (CM) Coordinators provide care coordination services which address the implementation of the care plan and ongoing care coordination. These services include:

- Working with the member to implement his/her care plan
- Assisting the member in navigating health, behavioral health, community, and social services systems such as housing, Alcoholics Anonymous, and smoking cessation classes
- Sharing options with the member for accessing care and providing information to the member regarding care planning
- Monitoring and supporting treatment adherence (including medication management and reconciliation)
- Managing referrals, coordination, and follow-up for needed services and providing support to ensure the needed services are offered and accessed
- Sharing information with all involved parties to monitor the member's conditions, health status, medications and their side effects
- Assisting in attainment of the member's goals
- Encouraging the member's decision making and continued participation in the case management program
- Creating and promoting linkages to other services and support
- Helping facilitate communication and understanding between CM members and PCPs, and other healthcare providers
- Identifying barriers to improving their adherence to treatment and medication management
- Accompanying the member to critical appointments when necessary – The NCM assesses the member's transportation needs and ability to attend medical appointments. The CM team explores different transportation options to ensure the member has transportation to medical care:
    - Assists the member in requesting non-medical transportation (NMT) services through the Medi-Cal managed care plan (MCP)

- Family/support person provides transportation
- Community partners, e.g., volunteer/church groups may accompany the member to critical appointments
- Paratransit provides van and taxi services to people with disabilities

The NCM assesses members' needs and maximizes different transportation options. The NCM assists members in applying for transportation such as Paratransit, NMT and/or non-emergency medical transportation (NEMT) for long term transportation needs. The following are situations that may require a CM team member to accompany a member to a medical appointment:

- Family/support person is unable to assist the member
- Member is awaiting alternate transportation arrangement, e.g., Paratransit and assistance of other family members
- Appointment is critical and without accompaniment, the member may miss the appointment
- Member with severe physical disability that is unsafe to be traveling alone
- Member may need guidance in a new route
- Face to face interpretation is needed
- Different treatment options are unclear
- Non-compliant member

PCP Coordination of Care

1. PCPs are responsible for coordinating the care of their NEMS MSO members who obtain services from providers both inside and outside of NEMS MSO network, including but not limited to:
   - Specialty visits and outpatient services
   - Specialty visits and outpatient services not available within the NEMS MSO that are authorized to be obtained from non-contracted providers.
   - Second opinions, whether obtained from contracted or non-contracted providers.
   - Hospital, skilled nursing, sub-acute care, rehabilitation facility care, and discharge planning, whether obtained from a contracted or non-contracted facility. The PCP ensures continuity of care between the ambulatory setting and inpatient setting.
   - Emergency care
   - Specialized services provided by community and waiver programs, including Women, Infants and Children Program (WIC), California Children's Services (CCS), Early Start, Regional Center, Tuberculosis directly observed therapy, among others.
2. When the PCP makes a referral, the PCP follows up to ensure that the service is received. The PCP requires that the provider of service sends a written report that includes the type and number of services provided and a plan for ongoing care.
3. The PCP may refer members to NEMS MSO Case Management (CM) who need coordination of care for in or out-of-network services, including specialty, ambulatory care, hospitalization, and emergency services.

NEMS MSO Coordination of Care

NEMS MSO coordinates care to ensure that members receiving treatment for acute or chronic conditions will have access to care and services with the PCP, specialists, hospital, and ancillary providers, as needed. The CM staff members identify individuals in need of coordination of care from the following sources:

- Existing prior authorizations in database
- PCP or specialists' referrals
- Referrals from the UM team
- Member/family direct inquiry
- Authorization requests
- Inquiries from out-of-network providers
- Inpatient census

Once the need for coordination of care is identified, the Case Manager works collaboratively with the member, family, PCP, specialists, ancillary providers, hospitals, community, and social services, etc. to coordinate care to ensure that the member receives appropriate treatment for acute and chronic conditions. The following are situations that require coordination of care:

1. Members receiving out-of-network services

While NEMS MSO requires that covered services be obtained from contracted providers, if a member is being treated for an acute condition by a non-contracted provider, a member may request continued care from a provider, including a hospital. NEMS MSO will review the member/provider request and the member's medical conditions to determine whether the treatment or care can be transferred to a contracted provider without compromising quality of care.

The member may be safely transferred to an in-network provider if the following criteria are met:

- MCG Guidelines or other treatment guidelines
- Community standards of practice
- Treatment or care can be provided by a provider in matching specialty
- Current treatment or care can be transitioned timely to another provider/facility without any delay in treatment or care
- Coordination of care can be resumed in a timely manner.
- Provider office is accessible to the member
- The receiving provider and facility can handle the member's conditions

Premature transfer of care may compromise quality of care. A member may need to continue care with an out-of-network provider for a period of time until it is safe to transfer care. Services can be extended for a period of time appropriate for the current treatment that the member is receiving for acute or chronic conditions:

- An acute condition – services to be provided for the duration of the acute condition.
- A serious chronic condition – services to be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider. Not to exceed 12 months from the termination of the provider contract.
- A pregnancy – except during the first and second trimester periods but including immediate post-partum period.

- A terminal illness – services to be provided for the duration of the terminal illness.
- Care of a newborn child between birth and 36 months of age. Services shall not exceed 12 months from the provider contract termination date.
- Surgery or other procedure authorized by NEMS MSO as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days from the provider contract termination date.

NEMS MSO will evaluate the needs of its provider network and may bring an out-of-network provider into NEMS MSO network so that members can continue to access care at the provider's office. The following are some considerations when NEMS MSO may bring an out-of-network provider in network:

- Provider is serving NEMS MSO members
- The specialty/subspecialty is lacking in-network
- Provider is in the NEMS MSO service area
- Provider accepts Medi-Cal members
- Provider agrees to accept MEMS MSO rates
- Provider will cooperate with and participate in NEMS MSO Quality Improvement, Utilization Management, and Member grievance and appeals processes.

The NEMS MSO UM and CM staff will identify the need for adding out-of-network providers and notify a NEMS MSO Provider Relations (PR) Coordinator for contracting. The NEMS MSO PR Coordinator will outreach to the provider's office. If the provider is interested in joining the NEMS MSO network, the PR Coordinator will initiate the contracting and credentialing process. Upon approval of contracting and credentialing, the PR Coordinator will notify the Health Plan in a timely manner about the addition of the provider.

2. Members transitioning from one care setting to another

Members may require care at an alternative care setting due to a change in medical conditions and needs. These are examples of change of care settings:

- From ambulatory to inpatient in planned or unplanned situations. The admission to inpatient setting maybe planned as in scheduled surgeries. Admissions can be unplanned in cases where members are experiencing acute symptoms of sufficient severity or serious impairment to bodily functions.
- From home hospice to inpatient hospice when family can no longer care for the member at a home setting.
- From inpatient to home when members are medically stable to be discharged to home.
- From hospital acute care to subacute care setting or vice versa.
- From an out-of-network hospital to an in-network hospital.

<u>From ambulatory setting to inpatient hospital or other settings</u>

Planned admission: The UMC reviews requests for authorizations for transfers from ambulatory to inpatient setting. The UMC reviews medical necessity and care setting for appropriateness based on NEMS MSO guidelines. The UMC will refer the case to CM if the medical guidelines do not support care at an inpatient setting. The CM works collaboratively

with the PCP, specialist, member, and MSO Medical Director to ensure that the level of care for the service is appropriate and meets the member's needs.

Unplanned admission: When CM staff members are aware of a member's urgent/emergent conditions that require inpatient admission, the CM staff contacts the PCP, specialist, family, hospital, and/or ambulance to make sure that the patient has a safe transfer to the inpatient setting.

From inpatient to another institution or ambulatory setting

Discharge Planning and Care Coordination: Discharge planning is a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Ongoing consultation with the patient care team and reassessment of the patient's changing medical, functional, social, and cognitive capabilities assure that the comprehensive needs of the patient are addressed.

NEMS treating physicians, UM Nurses, and other departmental staff perform discharge planning. . Patients and families are encouraged to participate in all phases of the discharge planning process. The process concludes with the coordination and implementation of services and transition to an appropriate level of care.

The UMC works closely with the member/caregiver, hospital discharge planner, and PCP to ensure a safe discharge. The discharge planning checklist provides guidance to the UMC when performing discharge planning (refer to Appendix 6 for Discharge Planning Checklist). The checklist includes the following:

1) Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
2) Documentation of pre-discharge factors, including an understanding of the medical condition by the member, or a representative of the member, as applicable, physical and mental function, financial resources, and social supports.
3) Services and anticipated level of care needed after discharge, type of placement preferred by the member/representative and hospital/institution, type of placement agreed to by the member/representative, specific agency/home recommendations by the hospital, specific agency/home agreed to by the member/representative, and pre-discharge counseling recommended.
4) Summary of the nature and outcome of the member/representative in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

The UMC ensures the authorization of post-discharge care needs, such as DME, home health, transportation, etc., during the discharge planning process. The UMC provides information regarding community services as needed by the member prior to discharge. The UMC works with the member/caregiver, hospital discharge planner, and PCP to address any barriers for the member to have a safe discharge.

The CM Home Care Nurse will contact NEMS MSO members who are discharged from a hospital or skilled nursing facility (excluding maternity and psychiatric admissions) within seven calendar days of discharge to ensure care is appropriately transferred from an inpatient to an ambulatory setting. The CM Home Care Nurse will visit the members at their home to coordinate care. The following are some of the services:

- Educate member:
    - Review of hospital discharge documents
    - Medication reconciliation
    - After hours physician on-call services
    - Disease management
    - Education material
- Notify PCP/specialist:
    - Medication refill
    - Home care referral
    - Durable medical equipment referral
    - PCP follow-up
    - Specialist referral
    - Mental health referral
    - Social worker referral
    - Community and social services referral

The CM Home Care Nurse will transition the care via telephone if the member refuses a home visit. Calls to the member may include the following topics:

- PCP visits – Ensure the member has appropriate follow-up appointments with the PCP
- Specialty visits – Ensure member has appropriate follow-up appointments with the specialist, as needed
- Ancillary services – Ensure member's health care needs, such as home care visits, durable medical equipment, medications, and follow-up tests are met
- Symptoms to report – Educate member on symptoms to report to providers, e.g., fever, dizziness, bleeding, and chest pain
- Medication reconciliation – Compare the medication orders from the hospital and the medications the member is taking

3. Members who need Long Term Care

NEMS MSO ensures the orderly transfer of members to a fee-for-service Long Term Care (LTC) facility that provides the level of care most appropriate to the member's condition. NEMS MSO UM team works with the NEMS MSO Medical Director, admitting doctor of the facility, and the facility staff to determine the level of care most appropriate to the member's condition. NEMS MSO works collaboratively with the hospital and/or facility staff to look for placement and provide authorization promptly for LTC admission.

If the admission exceeds the month of admission and the following month, the UM team notifies the Health Plan of the disenrollment request and updates the Health Plan of any changes and/or continuation of stay. A NEMS MSO member may be disenrolled from Medi-Cal managed care and receive LTC and/or skilled nursing care through fee-for-service Medi-

Cal, if the LTC admission exceeds the month of admission and the following month. Until the date of disenrollment, the medical group retains responsibility for managing the LTC stay.

4. CCS members who will soon reach 21 years of age

CCS members who reach 21 years of age will no longer qualify for the CCS program (refer to the policy and procedure on California Children's Services). A Case Manager reviews the CCS log quarterly to identify members who will be aged out of the CCS program within three months and starts case management for the member. A Case Manager contacts the CCS member and transitions the care from CCS to in-network providers.

The Case Manager takes into consideration the treatment that the member is receiving for acute and chronic conditions. The Case Manager may authorize treatment with an out-of-network provider if the member meets the criteria listed above. The Case Manager works with the NEMS MSO Medical Director, the member, PCP, specialists, and other providers to ensure a safe transfer to in-network providers.

5. Members who have physical, psychological, and social problems may need assistance in coordinating care

Members may have care needs for their acute and chronic conditions. A Case Manager will coordinate care with members, families, PCPs, specialists, and other resources, such as the Regional Center, Early Start, Early Intervention Program, and CCS to meet the member's needs (refer to policy and procedure on Case Management).

Documentation of Coordination of Care Services

Coordination and collaboration of the member's care is documented between the PCP and the referred service(s):

- The medical record reflects collaboration between the Regional Center/Early Start/Early Intervention program with the PCP (i.e., MD notes [ES/EI/DDS provider], referral from or to the Regional Center and/or Early Start program for ages 0-3).
- The medical record reflects coordination of specialist services with the Health Plan network.
- The medical record reflects that those members who would otherwise require care in a nursing facility or hospital, who are eligible for a Home and Community-Based Services (HCBS) Waiver have been referred.
- The medical record reflects that the member is receiving all medically necessary covered diagnostic, preventive, and treatment services through their PCP.

Quality Improvement

The NEMS MSO Quality Improvement Program relies on the following methods to evaluate coordination of care:

- Auditing medical records for appropriate follow-up care and referral practices, including monitoring the coordination of care between the PCP, specialist physicians, mental health practitioners, and public and community agencies

providing clinical or social services to NEMS MSO members. This review evaluates if the PCP is reviewing and initialing consultation/ referral/ diagnostic test reports, and if the PCP is following up on missed appointments. NEMS MSO will generate a corrective action plan for any chart that is out of compliance.

- Analyzing member and provider satisfaction surveys, focused studies, appeals, and grievances concerning continuity and coordination of care.
- Monitoring denials and modifications of care.

NEMS MSO implements corrective action to address specific or systemic issues concerning continuity and coordination of care.

Policy 16: Cultural Competency and Sensitivity Training

POLICY

Healthcare workers are responsible for adapting cultural competency and sensitivity to their field of work. Cultural competency includes knowledge, skills, and behaviors that allow providers and staff to work effectively with individuals and populations based on their language, race, ethnicity, culture, and sensitivity. All staff that interacts directly with patients will be required to attend cultural competency and sensitivity trainings on an annual basis.

PROCEDURE

Cultural Competency and Sensitivity Training at North East Medical Services will include the following:

- A power-point presentation that will include results of the pretest
- Presentation to include skills on working with people of Limited English Proficiency and varying cultural beliefs and practices.
- Presentation to include skills on working with people with disabilities

Online cultural competency and sensitivity training will be conducted annually.

Trainings will be updated and adapted on at least an annual basis.

Policy 17: Dental Services – Intravenous Sedation and General Anesthesia

POLICY

NEMS MSO is required to provide medically necessary anesthesia services in support of dental services rendered by Medi-Cal and Delta Dental providers, according to contractual and regulatory obligations. NEMS MSO is required to provide medically necessary oral screening assessments at each periodic assessment with dental referrals commencing at age one.

NEMS MSO covers medically necessary services administered in connection with dental services that are not provided by dentists or dental anesthesiologists, including:

- Reimbursement for contractually covered prescription drugs (as applicable)
- Laboratory services
- Pre-admission physical examinations required for dental offices
- Admission to ambulatory medical surgical settings or an inpatient hospital for a dental procedure, and facility fees, as applicable

Routine coverage of dental anesthesia for the comfort and convenience of the patient or the dental provider is not a covered benefit. Coverage for the cost of the dental procedure itself or the professional fee of the dentist performing the procedure is not the responsibility of NEMS MSO.

PROCEDURE

Preauthorization for dental anesthesia is required as stated in the NEMS MSO Utilization Management policy.

NEMS MSO authorizes and pays for medically necessary dental anesthesia services when the treating dentist and/or Delta Dental requests it.

NEMS MSO assists providers and members with the prior authorization process as a form of care coordination to avoid situations where services are unduly delayed.

Definitions

Medically necessary screening/oral assessment is screening provided in conjunction with each periodic assessment. Dental anesthesia services may be required due to patient age, underlying medical condition, clinical status, or the severity of the dental procedure. Patients less than seven years of age, developmentally disabled, or who have an underlying medical condition that makes general anesthesia medically necessary are eligible.

Policy 18: Dental Fluoride Varnish

POLICY:
Fluoride varnish is a form of topical fluoride that is effective in preventing tooth decay. Fluoride varnish consists of a liquid formulation of concentrated fluoride that is painted directly on the coronal surfaces of teeth. The application of topical fluoride is quick, easy, and safe for babies and children. Due to its topical nature, fluoride varnish can be applied regardless of fluoride concentration in both community and private water systems or whether a child is taking dietary fluoride supplements. All Medi-Cal managed care health plan patients younger than the age of 21 may receive topical fluoride varnishes twice over a 12-month period (once every 6 months). A third topical fluoride varnish may be applicable if certain criteria, which must be documented, are met. All other NEMS patients should check with their insurance plans to verify how many fluoride varnishes are allowed over a 12-month period.

CHARACTERISTICS

Patients who have one or more of the following characteristics may be ideal for application of topical fluoride varnish:

- Presence or history of cavities
- Presence of white spot lesions
- Presence of excessive amounts of plaque
- Continues to drink from a bottle past the age of 1 year or sleeps with a bottle containing liquids other than water
- Developmental disability
- Chronic consumption of foods high in sugar, including fruit juice and medications
- Family members with a history of cavities

SCHEDULE

An oral health screening must be conducted prior to application of fluoride varnish. NEMS dental and/or pediatric staff will determine whether a patient meets the criteria for fluoride application or is due for varnish application. Age appropriate oral health anticipatory guidance will be offered to all parents or legal guardians. Post application instructions and if necessary, outside referrals, will be communicated afterwards. Fluoride varnish will be applied at regular dental visits for children ages 9 months to 6 years of age and at preventive medical visits for children upon the first tooth eruption to 5 years of age.

TRAINING

Fluoride varnish training information is available to all NEMS dental and pediatric providers, dental residents, and dental and medical assistants in the clinic. This information includes how to obtain fluoride varnish supplies; fluoride varnish application; and appropriate coordination of patient care (i.e., referrals, periodic dental assessments, and patient-caregiver anticipatory guidance).

PROCEDURE

Fluoride varnish can be swabbed directly onto the teeth and usually sets within one minute of contact with saliva. Application of fluoride varnish requires no special dental equipment and can be safely applied with minimal training by NEMS dental/pediatric providers, dental residents, or dental/medical assistants. Early application protects the primary teeth, and ideally should be performed as soon as possible after teeth initially erupt. NEMS dental/pediatric staff will thinly apply a layer of 5% sodium fluoride varnish to all coronal surfaces of erupted primary teeth. Proof of legal consent, medical history, and a completed oral screening form will be kept in the patient's electronic dental health record (EDR). The need for fluoride varnish placement will also be documented in the EDR.

SAFETY PRECAUTIONS

NEMS dental staff will remind caregivers to give the patients something to eat or drink before their dental visit. Caregivers will also be forewarned that the child's teeth may become temporarily discolored, but that the discoloration will be brushed off the following day. Patients may immediately leave after fluoride varnish application.

CONTRAINDICATIONS

Fluoride varnish application should not be given to any patients with large, open, carious lesions; gingival stomatitis; ulcerative gingivitis; intra-oral inflammation; or patients sensitive to Colophony; Colophonium; Ethyl Alcohol Anhydrous USP (38.58%); Shellac powder (16.92%); Rosin USP (29.61%); Copal; Sodium Fluoride (4.23%); Sodium Saccharin USP (0.04%); and any Cetostearyl Alcohol flavorings.

Policy 19: Direct Access to OB/GYN for Gynecology and Obstetrical Services

POLICY

The North East Medical Services (NEMS) Medical Group members may self-direct to any obstetrician/gynecologist (OB/GYN) or family practice physician within their medical group for gynecological and obstetrical services.

PROCEDURE

1. North East Medical Services (NEMS) medical group members may self-direct to any OB/GYN or family practice physician within their medical group for covered routine and preventive gynecological and obstetrical services. A NEMS medical group member will not be required to obtain prior approval from her primary care provider (PCP).

2. The OB/GYN or family practice physician communicates with the member's PCP regarding the member's condition, treatment, and any need for follow-up care.

Definitions

OB/GYN is a provider who specializes in women's health.

Policy 20: Disenrollment from Medi-Cal Managed Care

POLICY

1. The Health Care Options program (HCO) is the agent of the Department of Health Care Services (DHCS) that is responsible for disenrollment processing and approval for eligible Medi-Cal members.
2. Health plans cannot disenroll a member. NEMS MSO assists members who are requesting disenrollment and in certain cases are responsible for initiating the disenrollment process.
3. NEMS MSO provides all medically necessary covered services to the member until disenrollment is effective.
4. NEMS MSO assists with transition to the Medi-Cal fee-for-service program, including the transfer of medical records.

SCOPE

1. A separate policy governs disenrollment because of an irreconcilable breakdown in the physician-patient relationship.
2. Separate policies govern the case management process employed when a member is eligible for disenrollment because the member enters a long-term care facility or is a candidate for a major organ transplant.

PROCEDURE

1. NEMS MSO informs members and providers about disenrollment criteria, including when:
   - A member's eligibility for enrollment as a Medi-Cal beneficiary is terminated.
   - The Health Care Options Program (HCO) incorrectly enrolled or assigned a member to a plan not of his/her choosing, as indicated on the enrollment request form completed by the beneficiary.
   - A member was enrolled in the plan due to incorrect information provided by the HCO or due to prohibited marketing practices by the plan.
   - A member's request for disenrollment is due to plan merger or reorganization.
   - There is a change of a member's place of residence to outside the plan's service area.
   - A member requests the disenrollment for any reason and the request is not made during any restricted disenrollment period for that member.
   - The member or NEMS MSO requests disenrollment for good cause, as specified below, when the request is made during any restricted disenrollment period for the member. For the purposes of this subsection, good cause for disenrollment means one of the following:
     - The member requires Medi-Cal services that are excluded under the terms of the plan's contract, and which can be obtained only if the member disenrolls from the health plan.
     - NEMS MSO requests disenrollment because the member fraudulently uses or permits to be used the member's Medi-Cal coverage under the plan.
     - NEMS MSO or the member requests the disenrollment because of an irreconcilable breakdown in the physician-patient relationship.
     - NEMS MSO or the member requests the disenrollment for any other reasons determined by the department to constitute good cause.

- The member requests disenrollment for one of the reasons specified for exemption from plan enrollment and meets specified criteria:
    - An American Indian who has been accepted to receive health care services from the Indian Health Services on a fee-forservice basis.
    - A person who is being treated for a complex medical condition (medical exemption), as defined in Title 28, Section 53887. A NEMS MSO member is eligible if they have been a NEMS MSO member for 90 days or less, are under treatment by a medical provider that is not contracted with a San Francisco County Local Initiative plan and started treatment or was scheduled for treatment before their NEMS MSO effective date.

2. NEMS MSO assists members who are requesting disenrollment and in certain cases are responsible for initiating the disenrollment process.
    a) NEMS MSO makes disenrollment forms available to members. NEMS MSO mails a form within three working days after receiving a telephone or written request. The member submits the form to HCO in the postage-paid envelope provided.
    b) NEMS MSO informs members that they may contact HCO to request disenrollment and to inquire about forms and procedures.
    c) NEMS MSO provides the health plan's Member Services telephone number to members who request information about disenrollment. Health plan may submit disenrollment forms on behalf of its members.
    d) NEMS MSO provides HCO with the name of the correctional facility and the date of incarceration when they are informed that a member has been incarcerated.
    e) When NEMS MSO receives a call requesting disenrollment because the member is in foster care, the Adoption Assistance Program or Child Protective Services in another county, the representative refers the caller directly to HCO.
    f) NEMS MSO provides HCO with a member's new address when the address is reported by the beneficiary.
    g) Upon request, NEMS MSO assists HCO in gathering information necessary to process a disenrollment.
    h) NEMS MSO initiates an expedited disenrollment when:
        - NEMS MSO admits a member to a long-term care facility and the projected length of stay is longer than the month of admission and the following month.
        - A member has been referred to a Medi-Cal approved Transplant Center, is determined to be a candidate for a major organ transplant and has received prior authorization by the Medi-Cal Field Office.
3. NEMS MSO provides all medically necessary covered services to the member until disenrollment is effective.
    a) Unless the request is an expedited disenrollment, disenrollment is effective only when confirmed by the Medi-Cal Eligibility Data System (MEDS) update that is provided monthly to the health plan.
    b) When a member meets the requirements for an expedited disenrollment due to a length of stay at a long-term facility beyond the month of admission and the following month, the disenrollment is effective the first day of the following month, if the request is made at least 30 days in advance.
    c) When a member meets the requirements for an expedited disenrollment because a major organ transplant has received prior authorization by the Medi-Cal Field Office, the effective date of disenrollment will be retroactive to the beginning of the month in

which the transplant is approved. All services during the month are billed to the Medi-Cal fee-for-service program.

4. NEMS MSO assists with the transition to the Medi-Cal feeforservice program, including the transfer of medical records.

MEMBER DISENROLLMENT

Members may self-disenroll from health plan coverage at any time.
Members may also be disenrolled by health plan upon written notice if the member did any of the following:

- Provided information that is materially false or misrepresented on any enrollment application or any other health plan form
- Permitted a non-Member to use his or her Member ID to obtain services and benefits
- Obtained or attempted to obtain services or benefits under NEMS MSO by means of false, materially misleading, or fraudulent information, acts or omissions
- Engaged in disruptive behavior to NEMS MSO personnel or the providers of service (when such conduct is not corrected after written notice by NEMS MSO)
- Threatened the life or well-being of NEMS personnel or the providers of service.

Medi-Cal Member Disenrollment for Long-Term Care (LTC)

A NEMS MSO member may be disenrolled from Medi-Cal managed care and receive LTC and/or skilled nursing care through fee-for-service Medi-Cal, if the LTC admission exceeds the month of admission and the following month. Disenrollment, if requested and approved, may become effective on the first day of the second month following the member's month of admission to an LTC facility. Disenrollment requests are the responsibility of the medical group and are directed to the Health Plan UM Department to process. NEMS MSO must notify the Health Plan of all members admitted for skilled nursing care by submitting notification of admission by fax or by email. Medically necessary services at the LTC facility are covered by the medical group from the time of admission and up to one month after the month of admission. Until the date of disenrollment, the medical group retains responsibility for the payment of LTC costs.

Medi-Cal Member Disenrollment for Major Organ Transplant

Health plan members who are eligible and pre-authorized for major organ transplants are disenrolled from managed care Medi-Cal into fee-for-services Medi-Cal. NEMS MSO notifies the health plan of all transplant cases and transplant related investigational/experimental services. If the physician at the transplant center considers the member a suitable candidate for transplant, the provider will submit a prior authorization to the Medi-Cal Field Office. If a prior authorization is granted, the transplant center and NEMS UMC coordinates the submission of a disenrollment form to the health plan and/or the transplant authorization to HCO. The effective date of disenrollment will be retroactive to the beginning of the month in which the transplant was approved. NEMS MSO is responsible for the costs of covered medical care, including the costs of transplant evaluation, organ acquisition and bone marrow search, until the effective date of disenrollment.

Medi-Cal Member Disenrollment for Complex Medical Conditions

A NEMS MSO member is eligible for disenrollment for complex medical conditions (as defined by state law) if they have been an NEMS MSO member for 90 days or less, are under treatment by a non-NEMS provider, and started or was scheduled for treatment before their NEMS MSO effective date. Disenrollment requests are the responsibility of the NEMS MSO and are directed to HCO at (800) 430-4263.

Disenrollment Agencies

Disenrollment requests will be addressed to the appropriate agency:

Line of Business	Agency	Telephone Number
Medi-Cal	Health Care Options	(800) 430-4263
Healthy Kids	San Francisco Health Plan	(415) 547-7800

Policy 21: Early Periodic Screening, Diagnosis and Treatment (EPSDT)

POLICY

NEMS makes Early Periodic Screening, Diagnosis and Treatment (EPSDT) services available to Medi-Cal members under the age of 21 as mandated by federal and state legislation.

PROCEDURE

1. The NEMS medical group informs plan and medical group case managers, primary care providers and members about EPSDT services available to Medi-Cal members less than 21 years of age. Examples of EPSDT services include:
   - Screening services provided at intervals which meet reasonable standards of medical and dental practice and at other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screening services must include, at minimum, a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests (including blood lead level assessment appropriate for age and risk factors); and health education (including anticipatory guidance).
   - Vision services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses.
   - Dental services provided at intervals which meet reasonable standards of dental practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Dental services must include, at a minimum, treatment for relief of pain and infections, restoration of teeth, and maintenance of dental health.
   - Hearing services provided at intervals which meet reasonable standards of medical practice and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.
   - Other necessary health care, diagnostic services, treatment, and measures, as described in 42 USC 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.

2. Primary care providers (PCPs) are responsible for identifying members who are eligible for EPSDT services during regular health assessment and screening visits or at any other visit. The member, the member's parent/guardian or other family member, or any health professional (in or outside of the NEMS network) may also identify the need for services.

3. Once a need is identified, the provider or the plan or medical group case manager refers for EPSDT services and assures that there is coordination of care between the provider of services and the PCP, including documentation in the medical record.

The NEMS MSO case management team provides case management services to members with special healthcare needs and who have had private duty nurse services approved due to medical necessity. The Nurse Case Manager notifies the health plan's case management team about all members approved for private duty nurse services and coordinates care with members, providers, and the health plan.

Resources for EPSDT Services:

- California Children's Services (CCS): Visit the county office's website for contact information
- EPSDT SS Coordinator, Children's Medical Services Branch: 714 P Street, Room 350, P.O. Box 942732, Sacramento, CA 94234-7320
- Regional Centers: Visit the county office's website for contact information
- County Behavioral Health Services: Visit the county office's website for contact information
- Denti-Cal: Toll Free Member Line, (800) 322-6384

4. NEMS shall provide or arrange and pay for EPSDT services including case management and nursing services as defined in Title XXII, CCR, Section 51184 except when EPSDT services are provided by another entity, such as CCS, schools, Regional Centers, or Behavioral Health Services.

5. EPSDT services are approved when medically necessary. Upon the approval of the services, the UMC refers EPSDT cases that may qualify for school district services, CCS, Early Start, and Regional Center to the NEMS case management (CM) team. The CM team coordinates appropriate referrals to the school district, CCS, Early Start, and Regional Center as needed. The UM team continues to approve medically necessary services until it is confirmed that the child will get the requested services at the level needed through the school district, CCS, Early Start, and Regional Center.

DEFINITIONS

1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are mandated by the federal government and include:
    - medically necessary screening, vision, hearing and dental, which are also referred to as Child Health and Disability Prevention (CHDP) services
    - medically necessary services to correct or ameliorate a defect, physical or mental illness, or a medical condition even if the service or item is not a Medi-Cal benefit.
2. EPSDT services are services that are medically necessary and available to those Medi-Cal beneficiaries who are eligible for coverage by CCS, Children's Medical Services, Early Start, Regional Center, County Behavioral Health Services, and other carve-out programs.

Policy 22: Early Start Program

The local regional center's Early Start program provides early intervention services to infants and toddlers, up to 36 months of age, who have a developmental delay or established risk conditions that could lead to a delay. Services are provided in a coordinated, family-centered system through the local regional center or a local education agency.

Infants and toddlers from birth to age 36 months may be eligible for Early Start if they meet one of the following criteria:

1. Show a significant delay of at least 33% in one or more developmental areas:
    - Cognitive
    - Physical (motor, vision and hearing)
    - Communication
    - Social or emotional
    - Adaptive
2. Have an established risk condition of known etiology, with a high probability of leading to developmental delay.
3. At high risk of having substantial developmental disability due to a combination of biomedical risk factors.

Referral for the Early Start program is made through the local regional center, such as Golden Gate Regional Center for San Francisco County and San Mateo County or San Andreas Regional Center for Santa Clara County. Eligibility for the program is based on results of the intake assessment and other factors.

Eligible infants and toddlers may receive a variety of services dependent upon the child's development and the family's capacity to meet those needs. Services may include:

- Assistive technology (devices and services)
- Hearing and vision services
- Family training, counseling, and home visits
- Medical services necessary for diagnosis or evaluation
- Nursing and nutrition services
- Occupational and physical therapy
- Psychological and social work services
- Service coordination
- Speech and language services
- Transportation and related costs necessary to receive services

Early Start services may end upon individual or family request or if the regional center loses contact with the individual or family.

POLICY

PCPs are responsible for identification and referral of eligible children to the Early Start (ES) program. NEMS MSO will provide care coordination services when indicated or requested by the member or provider. Services provided by the Early Start program are not a part of the health plan's benefit but will enhance the services available to eligible members. PCPs and NEMS MSO continue to provide medically necessary covered services for members receiving

Early Start services. Coordination and collaboration between PCP and the Early Start program, including referral to the program, is documented in the member's record.

Referral to the Early Start Program can be made to the local regional center via telephone, fax or mail.

PROCEDURE

PCPs maintain responsibility for basic case management and collaboration with the local Regional Center or local ES Program to determine the medically necessary diagnostic and preventive services and treatment plans for members participating in the ES program. As appropriate, providers will participate in the development and monitoring of the Individualized Family Service Plan (IFSP) managed by the Early Start referral agency.

Tracking Early Start Members in the UM System

Health Plan provides ES/regional center member lists to NEMS MSO on a scheduled basis. Active ES/regional center members will be marked in the NEMS MSO UM system as regional center members (e.g., GGRC), enabling an alert to appear and notify the UM and CM staff about a member's regional center status. UM and CM staff will follow-up with members, providers, and Early Start's case managers as needed to coordinate care.

Case Management for Early Start Members

Upon PCP request, NEMS MSO will provide case management support to assure timely referral to Early Start and work with the member's family to educate them on reasons for referral and the resources made available through the program. Case management activities may include:

- Outreach to member/family to verify status of program eligibility
- Explain reasons for referral and/or available program resources
- Educate member/family to contact NEMS MSO should they experience difficulty in accessing or coordinating care
- Referral to NEMS Complex Case Management if member has complex medical conditions and would benefit from additional case management services

The local regional center will assess members ages 3 and older with developmental delay/disability for the Lanterman Program, as well as connect them to the school district for evaluation of eligibility for continued services at the school. NEMS MSO is responsible for continuing any medically necessary services not provided by those entities. The NEMS MSO Care Coordinator will coordinate with the local regional center and school district in the transition.

NEMS MSO will track the status of regional center (e.g., GGRC) members in the UM system to maintain an updated member list to ensure members receive coordinated care. If potential duplication of services is identified, the UMC/Care Coordinator will contact the case managers at the regional center to coordinate care to prevent duplication of services.

Policy 23: Economic Profiling

Health and Safety Code section 1367, subdivision (g), which requires organizations to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

POLICY

NEMS UM makes decisions based on a member's eligibility, benefits, medical necessity, and the medical needs specific to the member. There is no reward for making denial decisions

PROCEDURE

1. NEMS UM makes decisions based on member's eligibility, benefits, medical necessity, and the medical needs specific to the member.
2. All UM team members (physician and non-physician members) sign the affirmative statement and attest to the following:
   - UM decision making is based only on appropriateness of care and service and existence of coverage.
   - NEMS 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.
3. Practitioners are ensured independence and impartiality in making referral decisions which will not influence:
   - Hiring
   - Compensation
   - Termination
   - Promotion
   - Any other similar matters
4. Interrater Reliability Studies are performed annually to ensure that denial decisions are made appropriately by qualified medical providers and not hindered by fiscal and administrative management.

Policy 24: Emergency Care Procedures

An "Emergency Service" is a medical service to address a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in disability or death, i.e., a situation that:

1. Places the member's health in serious jeopardy.
2. May result in serious impairment to bodily functions.
3. May result in serious dysfunction of any bodily organ or part.

POLICY

NEMS MSO provides, arranges for, or otherwise facilitates all needed emergency services, including appropriate coverage of cost. Emergency services are covered when necessary to screen and/or stabilize a client without pre-certification in cases where a *prudent layperson*, acting reasonably, would have believed that an emergency exists.

1. Emergency services are covered to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
    - A prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment.
    - A prudent layperson is considered to have acted “reasonably” if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.
    - Requests cannot be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the claimant (e.g., the member is unconscious and in need of immediate care at the time medical treatment is required).
2. Emergency services do not require authorization prior to treatment.
3. Emergency services are at no cost to Medi-Cal members. Requests cannot be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the member.

DEFINITION

Urgent Services
Urgent Services are defined as those required to diagnosis and treat medical problems that require same day treatment. This may occur when the PCP is unavailable to treat the member in the office. Urgent services ordinarily require PCP authorization prior to treatment.

Non-Urgent Services
Non-Urgent Services are defined as those that do not require same day treatment and can be referred to the PCP for follow-up.

"After hours" is defined as "the period between the close of regular business hours and the opening of the next regular business day".

PROCEDURE

1. Physician Access After-Hours

Participating providers must maintain reasonable hours of operation and provide 24-hour access to primary care via extended office hours, urgent care centers, emergency departments, and 24-hour physician on-call systems.

24-hour access to care must include a physician or mid-level provider who is available for contact after-hours, either in person or via telephone.

After-hour physician contacts should be documented in the member's permanent medical record. Documentation should be forwarded to the member's PCP of record. After-hours contact should include appropriate triage for emergency care.

2. Member Self-Referral to Emergency Room

In all instances when a member presents him/herself at an emergency room for diagnosis and treatment of illness or injury, the emergency room performs appropriate triage of the severity of illness/injury. For cases determined to be true emergencies, diagnosis and treatment should start immediately. The Emergency Physician is expected to transmit documentation of the ER treatment to the patient's PCP, which include a plan for PCP consultation and follow-up care.

For emergency situations as defined by the examining physician, assessment and treatment must proceed until the patient is stabilized. Authorization is not required. The emergency room staff must conduct a psychiatric screening exam and treat, relieve or eliminate the psychiatric emergency.

In routine and non-urgent situations, treatment authorization by the PCP is required after completing the medical screening exam and stabilizing the condition. If the PCP does not respond, the Emergency Room/Department will proceed with treatment. Documentation and proof of the Emergency Department's attempt to reach the PCP and Medical Group and failure to respond within 30 minutes of the first contact attempt will be accepted as authorization to diagnose and treat.

3. PCP Referral of Member to Emergency Room

The PCP provides 24-hour access to members. After hours, this may involve telephone advice or triage. In routine or urgent situations, the PCP may determine whether or not care in the emergency room is appropriate. The PCP is expected to arrange urgent or follow-up care with the member.

The PCP may determine that the condition is not emergent and instruct the patient to another treatment location. If the member is unwilling to go to the treatment location designated by the

PCP, and insists on treatment at the emergency room, the member will be financially responsible for the service. NEMS MSO will contact the member to discuss how to appropriately obtain services.

4. Emergency Services Out of Area

NEMS MSO covers emergency services outside of the service area. Should a member require reimbursement for the emergency services, the member must obtain complete documentation of their condition and care provided.

Complete documentation includes:

- Descriptions of the problem/complaint/symptoms/condition that you were experiencing that lead you to believe that you were having a medical emergency.
- Diagnosis of condition (copy of the emergency room/physician report).
- Treatment(s) occurred at the emergency room/center.
- Treatment(s) recommended as follow-up care, if any.
- Copies of the receipt indicating the currency in which it was paid.
- Amount paid for this care.

5. Out-of-Area Emergency Hospital Admissions

The NEMS MSO UM Department will work to coordinate and manage the care of members admitted out-of-area for emergency medical problems. The UM Department will work to return the member to care within the Medical Group's network as soon as medically appropriate. This policy ordinarily applies to members admitted to the hospital and can apply to members admitted at other levels of care, e.g., to a skilled nursing facility (SNF).

After notification of an admission to an out-of-area hospital, the NEMS MSO Case Manager or UM Nurse/Coordinator will begin follow-up with the admission. The UM Nurse records the daily concurrent reviews for the out-of-network member and submits them to the Medical Director for evaluation. The goal of out-of-network UM is to monitor the course of medical care until the patient has stabilized or improved to the point that the patient can safely return to an innetwork facility. At all times, an appropriate level of service must be maintained.

The member's PCP shall be communicated with during the transfer process as necessary. This may include arranging follow-up care to the in-network hospital or the PCP's office after the transfer is successfully facilitated.

Conditions or situations in which premature transfer of care may compromise quality of care includes, but are not limited to:

- Intensive care monitoring
- Unstable cardiac conditions
- Unstable spinal fractures
- Ongoing emergency treatments (chemotherapy, dialysis, etc)
- Rapidly fluctuating or unstable vital signs
- Trauma or multiple traumatic injuries

- Any medical condition that the admitting provider deems unsafe or unstable to transfer
- The in-network hospital does not offer equivalent level of care or specialty care required

Policy 25: End of Life Services

Terminally ill members, age 18 or older with the capacity to make medical decisions are permitted to request & receive prescriptions for aid-in-dying medications if certain conditions are met. Provision of these services by health care providers is voluntary and refusal to provide these services will not place any physician at risk for civil, criminal, or professional penalties.

End of Life (EOL) Services include consultations and the prescription of an aid-in-dying drug. EOL services are a "carve out" for Medi-Cal Managed Care Health Plans (MCPs) and are covered by Medi-Cal FFS. Members are responsible for finding a Medi-Cal FFS Physician for all aspects of the EOL benefit.

1. During an unrelated visit with an MCP physician, a member may provide an oral request for EOL services. If the physician is also enrolled with the Department of Health Care Services (DHCS) as a Medi-Cal FFS provider, that physician may elect to become the member's attending physician as he or she proceeds through the steps in obtaining EOL services.
2. EOL services following the initial visit are no longer the responsibility of NEMS MSO and must be completed by a Medi-Cal FFS attending physician, or a Medi-Cal FFS consulting physician.
3. Alternatively, if a NEMS MSO physician is not a Medi-Cal FFS provider, the physician may document the oral request in his or her medical records as part of the visit. However, the NEMS MSO physician should advise the member that following the initial visit he or she must select a Medi-Cal FFS physician to satisfy all of the remaining requirements.

Reference:
Department of Health Care Services All Plan Letter 16-006, June 8, 2016

Policy 26: Exclusion/Sanction Screening for Out of Network Providers

The NEMS UM team verifies that out-of-network providers are not suspended or sanctioned prior to authorization of services.

POLICY

1. The UM team verifies that out-of-network providers have not been suspended, made ineligible, excluded, sanctioned, or opted out of participation under Medi-Cal, prior to the authorization of services. Out-of-Network provider is defined as a provider who is not in the health plan network.

PROCEDURE

1. NEMS UM verifies that out-of-network providers have not been suspended, made ineligible, excluded, sanctioned, or opted out of participation under Medi-Cal, prior to the authorization of services utilizing the following sources:

a) Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) Database
b) System for Award Management (SAM) List
c) State Suspended & Ineligible List

2. Process of verification via OIG, SAM, and State Suspended & Ineligible List

A. Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) Database

General Information: OIG is the federal government agency dedicated to combating fraud, waste, and abuse, and to improve the Department of Health and Human Services. Individuals and entities listed on the OIG Exclusions list are excluded from federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that appear on the exclusion list cannot receive payment from federal healthcare programs directly or indirectly.
Link: https://exclusions.oig.hhs.gov/

1. Go to link
2. Select what you are trying to search (entity or individual)
3. Type in individual or entity's name
4. Select Search
5. Print search results with the date verification is made
6. Review results
    a. If there is a name match, click into each matched result to confirm if it is the same individual or entity. Due to not having an individual's SSN or an entity's EIN on hand to verify the results, confirm with the individual's profession (general), specialty, and address.
    b. Save the confirmations of each match, or no match, and save with original search result document.
    c. If there is a confirmed match, no authorization should be made.

B. System for Award Management (SAM)
Individuals and entities must have an active registration in SAM to do business with the Federal Government. Searching an individual or entity on SAM will help identify if a business is a registered entity, an excluded entity, or not enrolled. If an individual or entity is listed on an exclusion list, they cannot be receiving payment or contracts from federal healthcare programs directly or indirectly.
Link: https://sam.gov/search/

1. Go to link
2. Under Select Domain, select "Entity Information" to open the menu. Under the Entity Information menu, select "Exclusions"
3. Under Filter By, Keyword Search, type in the NPI number or the provider's name
4. Click "Enter"
5. Print search results with the date verification is made
6. Review results
    a. If search returns exclusion results, click into each result with the name matching the individual or entity being checked and confirm if it is the same. Print each additional page and save with original search result document.
    b. If there is a confirmed match, no authorization should be made.

C. Medi-Cal Suspended or Ineligible List
Medi-Cal is required to suspend a Medi-Cal provider of healthcare services from participation in the Medi-Cal program when the individual or entity has been:

- convicted of a felony
- been convicted of misdemeanor involving fraud, abuse of Medi-Cal program or any patient
- been suspended from the federal Medicare or Medicaid programs
- Lost or surrendered a license, certificate, or approval to provide healthcare
- Breached a contractual agreement with the Department that explicitly specifies inclusion on this list as a consequence of the breach.

Link to List (monthly): https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx

Note: Provider Relations saves monthly lists in Shared drive with easy to print formatting.

1. Obtain excel list, ensure that it is in alphabetical order.
2. Find provider's name on list or where it would be in alphabetical order
3. Print the page where provider's name is or would be listed
    a. If no record, indicate where the provider would have been if listed and note "No Provider" with an arrow.
    b. If confirmed match found, no authorization may be issued to this provider.

Policy 27: Experimental and Investigational Services

The Health Plan is responsible for determining whether treatment is considered investigational or experimental. NEMS MSO refers all requests for experimental or investigational treatments, including clinical trials, to the Health Plan for initial determination, regardless of benefit exclusion, within the following timeframe:
1) Standard requests within 24 hours of receipt of request.
2) Expedited requests must be completed and faxed on the same day of member or physician request.
3) If the request is related to transplants, the information must be sent directly to the Health Plan's Case Management Transplant Department.
4). The denial of services considered experimental or investigational will be issued by the Health Plan.
5). An informational letter to the member and physician should be issued immediately when sending the experimental/investigational referral to the Health Plan.

When experimental or investigational treatments, including clinical trials are approved by the Health Plan, NEMS MSO provides coverage for all routine patient care costs related to the clinical trial if the member's treating physician, who is providing covered health care services to the member under the contract, recommends participation in the clinical trial. The participation in the clinical trial should have a meaningful potential to benefit the member. The clinical trial's endpoints should not be defined exclusively to test toxicity but shall have a therapeutic intent.

The "routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including:

1. Health care services typically provided absent a clinical trial.
2. Health care services required solely for the provision of the investigational drug, item, device, or service.
3. Health care services required for the clinically appropriate monitoring of the investigational item or service.
4. Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include the costs associated with the provision of any of the following:
1. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA) and that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that a member may require as a result of the treatment being provided for purposes of the clinical trial.
3. Any item or service that is provided solely to satisfy data collection and analysis needs and

that is not used in the clinical management of the patient.
4. Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the member's Health Plan.
5. Health care services customarily provided by the research sponsors free of charge for any member in the trial.
6. Experimental or investigational procedures outside of the scope of a clinical trial for cancer.

The treatment provided in a clinical trial should involve a drug that is exempt under federal regulations from a new drug application and is approved by one of the following:

- One of the National Institutes of Health
- The federal FDA, in the form of an investigational new drug application.
- The United States Department of Defense.
- The United States Veterans' Administration.

If a Health Plan does not review experimental/investigational services and delegates the function to NEMS MSO, NEMS MSO will send the TAR to an external reviewer in the same specialty for review. Denials deemed experimental issued to a member with a terminal illness must include the following items in the denial letter:
1. Specific medical and scientific reasons for denying coverage
2. Description of alternative treatment, service, or supplies covered by the Health Plan.

Policy 28: Family Planning Services

POLICY

Members have the right to access family planning services through any qualified family planning provider, including non-contracted providers, without prior authorization. A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to a member.

PROCEDURE

Under the Health Plan's guidelines, members can see any qualified provider, contracted and non-contracted, for family planning services without a PCP referral or NEMS MSO authorization. Under federal regulation, Medi-Cal recipients have open access to family planning services. NEMS MSO does not require prior authorization for the following family planning services:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical examination
- Laboratory tests, if medically indicated, as part of the decision-making process to choose a contraceptive method
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Provision of contraceptive pills, devices, and supplies
- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling
- Diagnosis and treatment of sexually transmitted diseases (STD)
- Screening, testing, and counseling of at-risk individuals for HIV and referral for treatment

Services NOT reimbursable are:

- Reversal of voluntary sterilization
- Hysterectomy for sterilization purposes only
- Transportation, parking, and childcare

NEMS MSO allows members to access any qualified family planning provider in-network or out-of-network. Contracted providers are required to obtain a signed informed consent form for all Medi-Cal members for all contraceptive methods, including sterilization.

<u>Contraceptive Supplies</u>

NEMS MSO provides a 12-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when

dispensed at one time at a member's request, by a qualified family planning provider or pharmacist, including out-of-network providers.

Absent clinical contraindications, NEMS MSO does not impose utilization controls limiting the supply of FDA-approved, self-administered hormone contraceptives dispensed or furnished by a provider, pharmacist, or other authorized location to an amount that is less than a 12-month supply.

Infertility Policy

Infertility diagnosis codes when billed with any procedure will be denied unless submitted with a valid, approved Treatment Authorization Request/Service Authorization Request (TAR/SAR).

An infertility evaluation may be appropriately initiated in an eligible Medi-Cal beneficiary after one year of regular unprotected intercourse in women under age 35 years and after six months of unprotected intercourse in women age 35 years and older.

However, the evaluation may be initiated sooner in women with **irregular menstrual cycles or known risk factors for infertility, such as endometriosis, a history of pelvic inflammatory disease, or reproductive tract malformations.** The most common causes of female infertility include: ovulatory dysfunction (age or non-age related), fallopian tube abnormalities (related to pelvic adhesions and infection), endometriosis, uterine abnormalities (congenital or acquired), and cervical factors.

A female infertility evaluation may be medically necessary and available for an eligible Medi-Cal beneficiary **after male infertility screening has been performed (with a reproductive history and two semen analyses) to evaluate for male contributory factors.**

Female infertility may be indicated under any of the following clinical scenarios with a valid, approved **Treatment Authorization Request/Service Authorization Request (TAR/SAR)**:

Laboratory Evaluation

Relevant labs include prolactin, FSH, LH, GnRH, progesterone, estradiol, TSH, and ACTH levels.

Hyperprolactinemia causes typical symptoms in premenopausal women and in men, but not in postmenopausal women.

Premenopausal women — Hyperprolactinemia in premenopausal women causes hypogonadism, with symptoms that include infertility, oligo menorrhea, or amenorrhea.

Menstrual cycle dysfunction — Excluding pregnancy, hyperprolactinemia accounts for approximately 10-20% of cases of amenorrhea. The mechanism appears to involve inhibition of luteinizing hormone (LH), and perhaps follicle-stimulating hormone (FSH) secretion, via inhibition of the release of gonadotropin-releasing hormone (GnRH). As a result, serum gonadotropin concentrations are normal or low, as in other causes of secondary hypogonadism.

These labs will also assist with screening for hyper/hypothyroidism, hormone-producing tumors (adrenal, ovarian), Cushing's disease, and congenital adrenal hyperplasia, which may contribute to infertility.

Assessment of ovulatory function

Assessment of ovulatory function is a key component of the evaluation of the female partner since ovulatory dysfunction is a common cause of infertility. The treatment of women with ovulatory dysfunction is aimed at improving or inducing ovulatory function; a variety of treatment strategies is available.

Women who have regular menses approximately every 28 days with molimina symptoms prior to menses (breast tenderness, bloating, fatigue, etc.) are most likely ovulatory. In women who do not describe their cycles as such, laboratory assessment of ovulation should be performed. Ovulation is most easily documented by a mid-luteal phase serum progesterone level, which should be obtained approximately one week before the expected menses. For a typical 28-day cycle, the test would be obtained on day 21. A progesterone level >3 ng/mL is evidence of recent ovulation.

An alternative is to have the patient use an over-the-counter urinary ovulation prediction kit. These kits detect luteinizing hormone (LH) and are highly effective for predicting the timing of the LH surge that reliably indicates ovulation. Home kits have a 5 to 10 percent false positive and false negative rate. Therefore, serum confirmation can be useful in patients who are unable to detect a urinary LH surge.

If work-up from laboratory evaluation and assessment of ovulatory function does not provide sufficient evidence of the reason for infertility, other modalities may be considered.

Imaging

Evaluation by imaging may be indicated if there are suspected abnormalities of the fallopian tube, uterus, endometrium, or cervix. Modalities used to assess the uterine cavity include saline infusion sonohysterography, three-dimensional sonography, hysterosalpingogram (HSG), hysterosalpingo-contrast sonography (HyCoSy), and hysteroscopy.

An assessment of fallopian tube patency may be medically necessary in women presenting with complaints of inability to conceive and histories of pelvic inflammatory disease (PID), previous ectopic pregnancies, hydro-salpinx, endometriosis, tubal occlusion, tubo-ovarian abscess (TOA), polycystic ovary syndrome, and hydrosalpinx.

If endometriosis or blocked fallopian tubes are suspected, laparoscopy with chromotubation, may be indicated.

POTENTIALLY MEDICALLY NECESSARY TREATMENT IN WOMEN WITH HISTORY OF SECONDARY INFERTILITY:
Hysteroscopic removal of intrauterine lesions (eg, fibroid, polyp, adhesions).

Combined laparoscopy and hysteroscopy — Some women who undergo diagnostic or therapeutic procedures for infertility may require both hysteroscopy and laparoscopy. As an example, a woman with ultrasound findings of an intrauterine lesion undergoing surgical treatment of endometriosis requires evaluation of the uterine cavity.

TREATMENT OF DISTAL TUBAL OCCLUSION may be determined to by medically necessary with an Approved Treatment Authorization Request:
Distal tubal obstruction is usually a sequela of salpingitis. Other causes are previous ectopic pregnancy, previous abdominal or pelvic surgery, and peritonitis.

Diagnosis — Distal tubal occlusion is usually diagnosed by hysterosalpingogram that shows dilated distal tube (hydrosalpinx). The diagnosis is established at the time of laparoscopy; chromopertubation leads to dilated distal tube with no passage of the dye.

Fimbrioplasty — Fimbrioplasty is performed for treatment of fimbrial phimosis, which is a partial obstruction of the distal end of the fallopian tube. The tube is patent, but there are adhesive bands that surround the terminal end. The longitudinal folds of the tube are usually preserved. Fimbrioplasty involves dividing the peritoneal adhesive bands that surround the fimbria.

Terminal salpingostomy may be determined to be medically necessary and **is performed to relieve tubal obstruction associated with hydrosalpinx.**

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/06/infertility-workup-for-the-womens-health-specialist

https://www.acog.org/womens-health/faqs/evaluating-infertility

https://journals.lww.com/greenjournal/Fulltext/2019/06000/Infertility_Workup_for_the_Women_s_Health.44.aspx

https://www.uptodate.com/contents/evaluation-of-female-infertility

https://www.ncbi.nlm.nih.gov/books/NBK556033/

https://speciality.medicaldialogues.in/infertility-workup-for-the-womens-health-specialist-acog-asrm-guideline

https://www.asrm.org/news-and-publications/practice-committee-documents/

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/06/infertility-workup-for-the-womens-health-specialist

https://www.uptodate.com/contents/treatments-for-female-infertility

Policy 29: Follow-up of Expedited Authorizations

PURPOSE:

1. Define the process to provide timely authorization of expedited requests
2. Define the process to follow-up with the requester, vendor, and member about expedited requests

POLICY:

Requests for expedited authorizations will be reviewed in a timely manner. Expedited authorization requests are requests where the provider indicates or the NEMS MSO determines that the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Examples of expedited requests may include oxygen, ventilator, and Synagis (palivizumab). NEMS MSO will follow-up with the requester, vendor, and member after authorization of the services to ensure that the services are provided in a timely manner.

A. Expedited Authorization

The request for expedited services is reviewed for medical necessity. Contracted providers should be utilized, if possible, to avoid any delay in services. If a non-contracted provider is authorized, the Utilization Management (UM) Coordinator notifies the Provider Relations Coordinator immediately so that a contract or letter of agreement can be negotiated.

Decisions to approve or deny the expedited authorization will be made within 72 hours of receipt of pertinent medical information. The UMC will fax the Treatment Authorization Request form with the approval/denial decision to the provider on the same day the decision is made. Should the request be denied, a written or electronic notification of denial will be sent to the provider and member within two working days of making the decision.

B. Follow-up of Expedited Authorization

Within two days after authorization of the expedited services, the UMC will contact the requester by phone to make sure that the services are being rendered. The UMC may also contact the vendor and member to facilitate the rendering of the services. In the event that any barriers are identified, the UMC works with the requester, vendor, and member to resolve the issues. The UMC notifies the UM Manager about the barriers identified. The UMC continues to check with the requester, vendor, and/or member every 1-3 days to ensure that services are being provided in a timely manner.

Policy 30: Fraud, Waste and Abuse

POLICY

NEMS MSO complies with all applicable Federal and state statutory, regulatory and other requirements related to the Medicare/Medicaid comprehensive program to detect, prevent and control Fraud, Waste and Abuse (FWA).

PROCEDURE

All Management/Administrative staff and all employees providing direct healthcare services receive FWA training on hire and at least annually. The training is provided by the NEMS Compliance Department.

Refer to Corporate Compliance Policy and Procedure "Detection and Prevention of Fraud, Waste, Abuse."

Policy 31: Genetic Testing

PURPOSE

To provide guidance for the Utilization Management (UM) team on the process to review requests for genetic testing.

POLICY

1) The UM team reviews all genetic testing requests. This policy addresses the hierarchy of genetic guidelines and how to access them to make appropriate genetic testing UM decisions.

2) Genetic testing requires prior authorization regardless of whether it is part of a procedure.

PROCEDURES

1) All genetic testing requests are reviewed by the UM team for appropriateness. The UMC collects relevant supporting documentation, such as benefit limits, reason for testing, pertinent medical history, and medical criteria for review.

2) Genetic testing is covered when the results of the genetic tests are necessary to differentiate between treatment options. Genetic testing is not covered to determine specific diagnoses or syndromes when such determination would not definitively alter the medical treatment of the member.

3) The uses of genetic testing include:

-Newborn screening	-Prenatal testing
-Diagnostic testing	-Predictive and presymptomatic testing
-Carrier testing	-Oncologic screening

4) UM has adopted the prenatal genetic testing guidelines recommended by the American College of Obstetricians and Gynecologists (ACOG). https://www.acog.org/en/Clinical

   a. **Prenatal screening tests:** Tests for fetal chromosomal abnormalities (prenatal aneuploidy), such as the Natera Panorama test. Noninvasive Prenatal Testing (NIPT) or Noninvasive Prenatal Screening (NIPS)(cell-free DNA) – A method of determining the risk that the fetus will be born with certain genetic abnormalities. This testing screens for certain chromosomal abnormalities by analyzing small fragments of the fetus' DNA that has crossed the placenta and are circulating in a pregnant woman's blood.

      ACOG recommends NIPT for all pregnant patients regardless of age or other risk factors.

   b. **Prenatal diagnostic tests:** Tests on cells from the fetus or placenta obtained through amniocentesis or chorionic villus sampling (CVS) is appropriate. A woman can choose to have diagnostic testing instead of screening tests. A number of technologies are used in prenatal diagnostic testing.

i. Karyotype—Missing, extra, or damaged chromosomes can be detected by taking a picture of the chromosomes and arranging them in order from largest to smallest.
ii. Fluorescence in situ hybridization (FISH): This technique can be used to detect common aneuploidies involving chromosomes 13, 18, and 21 and the X and Y chromosomes. Positive test results are confirmed with a karyotype.
iii. Chromosome microarray analysis: This test looks for different kinds of chromosome problems, including aneuploidy, throughout the entire set of chromosomes. It can find some chromosome problems that karyotyping can miss.
iv. DNA testing: Test for specific gene mutations is done if patient and partner are carriers of certain mutated gene such as the cystic fibrosis gene.

c. **Carrier screening:** Testing is performed on an asymptomatic individual to determine whether the person has an abnormal allele within a gene that is associated with a particular disorder. Carrier screening can be performed for one specific condition or for multiple disorders. Below is ACOG's recommendation for carrier screening:
i. Ethnic-specific, panethnic, and expanded carrier screening are acceptable strategies for pre-pregnancy and prenatal carrier screening.
ii. All patients who are considering pregnancy or are already pregnant should be offered carrier screening for cystic fibrosis, spinal muscular atrophy, a complete blood count with red blood cell indices and screening for thalassemia and hemoglobinopathies. Fragile X premutation carrier screening is recommended for women with a family history of fragile X-related disorders or intellectual disability suggestive of fragile X syndrome, or women with a personal history of unexplained ovarian insufficiency or ovarian failure or an elevated follicle-stimulating hormone (FSH) before age 40 years. Additional screening also may be indicated based on family history or specific ethnicity.
iii. Individuals with a family history of a genetic disorder may benefit from the identification of the specific familial mutation rather than carrier screening. Knowledge of the specific familial mutation may allow for more specific and rapid prenatal diagnosis.
iv. Carrier screening panels should not include conditions primarily associated with a disease of adult onset.
v. Carrier screening for a particular condition generally should be performed only once in a person's lifetime, and the results should be documented in the patient's health record.
vi. Carrier screening test panels that bundle individual genetic tests are approved. These tests include, but are not limited to, Natera's Horizon 4, 14, or 27 tests.

d. **Expanded carrier screening:** Screening panels may include options to screen for as many as several hundred conditions. Expanded carrier screening does not replace

previous risk-based screening recommendations. The determination of the appropriate screening approach for any individual patient should be based on the patient's family history and personal values after counseling. Given the multitude of conditions that can be included in expanded carrier screening panels, the disorders selected for inclusion should meet several of the following criteria:

i. Have a carrier frequency of 1 in 100 or greater
ii. Have a well-defined phenotype
iii. Have a detrimental effect on quality of life
iv. Cause cognitive or physical impairment
v. Require surgical or medical intervention
vi. Have an onset early in life
vii. Screened conditions should be able to be diagnosed prenatally and may afford opportunities for antenatal intervention to improve perinatal outcomes and changes to delivery management to optimize newborn and infant outcomes

e. **Screening for partner -** Partner is screened if the following criteria are met:
   i. If a woman is found to be a carrier for a specific condition, her reproductive partner should be offered screening to provide accurate genetic counseling for the couple with regard to the risk of having an affected child.
   ii. If the partner has a significant family history even if the woman is not found to be a carrier
   iii. Partner must be eligible with NEMS MSO at the time of service.

5) **Genetic Testing for Cancer**
Biomarker testing is a way to look for genes, proteins, and other substances (called biomarkers or tumor markers) that can provide information about cancer. Biomarker testing may help an oncologist make better-informed treatment recommendations to customize a patient's treatment plan. Patients with solid tumors and blood cancer can get biomarker testing. The results will show if there is a marker that can be treated with an FDA-approved targeted therapy, immunotherapy, or provide information about markers that are possibly being studied in clinical trials.

Genomic biomarker testing (genomic profiling) is usually recommended for patients with cancer that has spread or come back after treatment (advanced cancer). It is also recommended for certain malignancies, e.g. non-small cell lung cancer (NSCLC), regardless of staging, to assist with selecting initial therapy modalities.

There are multiple biomarker-defined patient subgroups, with evidence showing that treatment with targeted therapies has superior clinical outcomes when compared with traditional cytotoxic chemotherapy. Biomarker testing is done routinely to select treatment for people who are diagnosed with certain types of cancer, including NSCLC, breast cancer, and colorectal cancer.

The following biomarker testing will be approved, per the National Comprehensive Cancer Network (NCCN), Medi-Cal, or AIM Specialty Health Genetic Testing Clinical guidelines:

B-Cell Lymphoma
-EZH2, MYD88

Brain/Central Nervous System Cancers
-IDH1, IDH2, MGMT, 1p/19q, ATRX, TERT, H3F3A, HIST1H3B, BRAF, RELA, TP53

Breast Cancer
BRCA1 and BRCA2 gene analysis for the following**:**
-Patient with a family member with a known BRCA mutation
-Personal history of breast cancer plus one or more of the following:
- -Diagnosed at </= 45 years of age OR
- -Diagnosed at 46 – 50 years of age with:
  - -An additional breast cancer primary at any age
  - -One or more close blood relatives with breast cancer at any age
  - -One or more close blood relatives with prostate cancer (Gleason score >/= 7)
  - -An unknown or limited family history OR
- -Diagnosed at </= 60 years of age with triple negative breast cancer OR
- -Diagnosed at any age with:
  - -One or more close blood relatives with:
    - -Breast cancer diagnosed at </= 50 years of age OR
    - -Ovarian cancer OR
    - -Male breast cancer OR
    - -Metastatic prostate cancer OR
    - -Pancreatic cancer
  - -Two or more additional diagnoses of breast cancer at any age in patient and/or in close blood relatives OR
- -Ashkenazi Jewish ancestry OR

-Personal history of ovarian cancer (includes fallopian tube and primary peritoneal cancers) OR
-Personal history of male breast cancer OR
-Personal history of pancreatic cancer OR
-Personal history of metastatic prostate cancer (biopsy-proven and/or with radiologic evidence; includes distant metastasis and regional bed or nodes; not biochemical recurrence) OR
-Personal history of high-grade prostate cancer (Gleason score >/= 7) at any age with:
- -One or more close blood relatives (first-, second- or third-degree) with ovarian cancer, pancreatic cancer or metastatic prostate cancer at any age or breast cancer under 50 years of age OR
- -Two or more close blood relatives (first-, second- or third-degree relatives on the same side of the family) with breast or prostate cancer (any grade) at any age OR
- -Ashkenazi Jewish ancestry OR

-BRCA1/2 pathogenic/likely pathogenic variant detected by tumor profiling on any tumor type in the absence of germline pathogenic/likely pathogenic variant analysis OR
-For an individual without history of breast or ovarian cancer, but with one or more first- or second-degree blood relative meeting any of the above criteria OR
-For BRACAnalysis CDx testing for breast cancer, all of the following TAR criteria must be met:
- -Patient has metastatic breast cancer.
- -Patient is human epidermal growth factor receptor 2 (HER2)-negative.
- -Patient has previously been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting.

-Patient's additional treatment is contingent on the test results.

Breast Cancer Genomic Assays
Reverse transcriptase-polymerase chain reaction assay for breast cancer gene expression **21-gene (Onco*type* DX)** may be indicated in patients with newly diagnosed breast carcinoma when ALL of the following are present:
-Histology demonstrates ductal, lobular, mixed, or metaplastic carcinoma.
-Pathologic stage is I or II.
-Node status is pathologic N0 or N1.
- Pre-menopausal women who are axillary-node negative or any axillary-node micrometastasis is no greater than 2.0 millimeters
- Post-menopausal women who are axillary-node negative or have no more than 3 positive lymph nodes

-Primary tumor is estrogen and/or progesterone receptor-positive.
-Primary tumor is HER2 receptor-negative.
Test is predictive and prognostic and preferred by NCCN.
Outcome of testing will guide decision-making regarding adjuvant chemotherapy.

Breast Cancer Index (BCI)
-prognostic and predictive of the benefit of extended adjuvant endocrine therapy for a patient

Cholangiocarcinoma
-FGFR2
-FoundationOne® CDx (for consideration of pemigatinib)

Chronic Lymphocytic Leukemia (CLL)
-TP53, IGHV, BTK, PLCG2

Colorectal Cancer (for all patients):
-MMR/MSI testing

Advanced/Metastatic Colorectal Cancer (Stage IV):
-KRAS and NRAS mutations
-BRAF V600E mutation
-HER2 testing
-Praxis Extended RAS panel (for consideration of panitumumab therapy)

Endometrial Cancer
-POLE

Gastrointestinal Stromal Tumors (GIST)
-KIT, PDGFRA, SDHB, SDHC, SDHD, NF1, BRAF

Lung Cancer - patients with advanced NSCLC (Stage IIIB and above) + some patients with squamous cell carcinoma (i.e non-smokers, those under age 40):

-EGFR mutations
-ALK rearrangements
-NTRK gene fusion
-MET exon 14 skipping

-ROS1 rearrangements -RET rearrangement
-BRAF V600E mutation -PD-L1
Oncomine Dx Target Test (for consideration of dabrafenib/trametinib, crizotinib, gefitinib, pralsetinib)

Metastatic (Stage III or IV) Melanoma (Cutaneous)
-BRAF, KIT

Melanoma (Uveal – Eye)
-EIF1AX, SF3B1, BAP1, PRAME, GNAQ, GNA11 or DecisionDx – Uveal Melanoma

Multiple Myeloma
-Chromosomal Microarray Analysis (CMA) when cytogenetic (karyotype) and/or FISH analysis is uninformative

Neuroblastoma
-Chromosomal Microarray Analysis (CMA), MYCN, ALK

Ovarian, Fallopian Tube, or Primary Peritoneal Cancer
-BRCA1, BRCA 2
-myChoice CDx® (tissue, for consideration of niraparib and/or olaparib)
-FoundationOne® Liquid CDx is medically necessary in women with ovarian, fallopian tube, or primary peritoneal cancer when the patient meets criteria per the FDA label for treatment(s) for which this test has been approved as a companion diagnostic
▪ Coverage is excluded when tissue-based testing is available
▪ Coverage is excluded when the patient already meets criteria without the need for additional testing (e.g. patient meets criteria based on known genetic results)

Prostate Cancer (symptomatic cancer screening)
ExosomeDx (0005U) or SelectMDx (81479) is medically necessary for men ≥50 years considering initial biopsy when there is concern for prostate cancer as evidenced by a PSA of 3.1-10.0 ng/mL and none of the following:
• Treatment for benign prostatic hyperplasia in the past six months
• Treatment using a medication which impacts serum PSA levels within the past six months

PCA3 (81313) or ConfirmMDx (81551) is medically necessary for men ≥50 years with prior negative biopsy when repeat biopsy is being considered due to a PSA of 3.1-10.0 ng/mL. Assays not listed above are considered not medically necessary.

For metastatic castration-resistant prostate cancer, FoundationOne® CDx testing is approved for consideration of Olaparib.

Tumor Agnostic/All Applicable Solid Tumors
-Microsatellite Instability (MSI), NTRK 1/2/3, FoundationOne® CDx (for consideration of pembrolizumab)

T-Cell Lymphoma (Peripheral)
-TET2, IDH1/IDH2, RHOA, DNMT3A, STAT3, STAT5B

Thyroid Cancer
-BRAF, RET fusions

The following tests are **not** medically necessary (list may not be all inclusive):
• Topographic genotyping (e.g., PancraGEN®)
• Whole exome tumor sequencing for any indication
• Whole genome tumor sequencing for any indication

In addition, testing of a genetic variant or profile correlated with a known therapy which does not have clinical utility for the specific tumor type and disease characteristics, is not medically necessary.

6) All genetic testing requests are reviewed by a physician reviewer for medical necessity. Cases are reviewed according to the hierarchy of guidelines and can be approved when the following UM guidelines are met.

a. Medi-Cal or Medicare Guidelines:

i. For Medi-Cal members, the Medi-Cal guidelines take precedence over all others. Medi-Cal Molecular Pathology guidelines address the majority of genetic testing requests that NEMS receives. These guidelines can be found on the Medi-Cal website:

- https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/genecoun.pdf
- https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/pathmolec.pdf
- https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/tarandnoncd8.pdf

ii. For Medicare members, the Medicare guidelines take precedence over all others. The Medicare Coverage Database contains Medicare's medical necessity and coverage guidelines. These guidelines can be found on the CMS.gov website https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Their search engine looks for matches with the words in the title of the policy, so trying multiple search terms is sometimes necessary to find their policy.

b. Health Plan Guidelines:

When Medi-Cal and Medicare guidelines are not available, the UM team reviews health plan guidelines. Guidelines from a member's assigned health plan can be used to support a denial. Guidelines from other health plans can only be used as a reference or to support an approval. The following are the websites for health plan guidelines:

i. Anthem Blue Cross Medical Policies and Clinical UM Guidelines:
https://www.anthem.com/ca/provider/policies/clinical-guidelines/

ii. **Aetna Medical Clinical Policy Bulletins:**
https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#

iii. **Cigna Health Care Clinical Policies:**
https://cignaforhcp.cigna.com/app/resources/results/public?query=genetic

iv. **Health Net Medical Policies:**
https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/medical_policies.html#G

v. **United Health Care Clinical Guidelines** (type in the test name under Filtered Search):
https://www.uhcprovider.com/en/policies-protocols/clinical-guidelines.html

c. **MCG Health Guidelines:**
When Medi-Cal, Medicare, and a member's health plan guidelines are not available, the UM team searches for the MCG Health Guidelines which can be accessed on-line at:
https://login.mcg.com/account/login?returnUrl=https%3A%2F%2Fcgi.careguidelines.com%2F&ClientId=Careweb

d. **AIM Specialty Health Genetic Testing Clinical Guidelines**
When the resources above do not provide adequate guidelines for genetic testing, the UM team may use AIM Specialty Health guidelines to determine medical necessity:
https://aimspecialtyhealth.com/resources/clinical-guidelines/genetic-testing/

7) The physician reviewer may approve genetic testing in the absence of UM guidelines if all of the following medical necessity criteria are met:

a. The member displays clinical features or is at direct risk of inheriting the mutation in question.
b. The test results will be used to develop a clinically useful approach or course of treatment, or to cease unnecessary monitoring or treatments for the individual being tested. Clinically useful test results allow providers to do at least one of the following:
    i. Inform interventions that could prevent or delay disease onset
    ii. Detect disease at an earlier stage when treatment is more effective
    iii. Manage the treatable progression of an established disease
    iv. Treat current symptoms significantly affecting a member's health
    v. Guide decision making for the member's current or planned pregnancy
c. The genetic disorder could not be diagnosed through conventional diagnostic studies.
d. The member has not previously undergone genetic testing for the disorder, unless significant changes in testing technology or treatments indicate that test results or outcomes may change due to repeat testing.
e. Technical and clinical performance of the genetic test is supported by published peer-reviewed medical literature.

8) The physician reviewer may consider approval of a genetic test that is supported by published peer-reviewed medical literature. The resources listed below are for reference and can be used as evidence to support an approval.

a. Genetic Testing Registry (GTR)

a. A registry of genetic tests and laboratories are available. The UM team can find alternative lab choices for genetic testing that is requested.

b. GeneReviews

a. A collection of expert-authored, peer-reviewed disease descriptions on the NCBI Bookshelf that apply genetic testing to the diagnosis, management, and genetic counseling of patients and families with specific inherited conditions.
b. https://www.ncbi.nlm.nih.gov/books/NBK1116/

c. National Comprehensive Cancer Network (NCCN)

a. UM staff member creates own login and searches for genetic testing guidelines for specific cancer condition.
b. https://www.nccn.org/

d. UpToDate

Clinical practice guidelines on the website:
https://www.uptodate.com/login

9) In absence of a UM guideline, the UM team sends the case to an external reviewer in the same specialty for review. Questions to the external reviewer should be specific to the genetic test and may also include the following general questions:

a. Is the request for the genetic test (name) medically necessary for this patient?
b. If the request is not medically necessary, under what condition is the genetic test (name) medically necessary?
c. Are there other more cost-effective alternatives to this genetic test?
d. Will the genetic test results be able to guide treatment options?

10) Genetic testing requires prior authorization. The genetic testing vendor must ensure that proper authorization has been obtained prior to performing genetic testing. The ordering provider may sometimes assist in obtaining the prior authorization. Genetic testing performed without prior authorization will be denied. Effective 07/01/2022, NEMS MSO will not require prior authorization for biomarker testing for members with advanced or metastatic stage 3 or 4 cancer.

References:

1) ACOG Prenatal Genetic Screening Tests (2020):
https://www.acog.org/womens-health/faqs/~/link.aspx?_id=3E5EF64F6EE4449CA7005B98782686B4&_z=z

2) ACOG Prenatal Diagnostic Tests (2020):
https://www.acog.org/womens-health/faqs/prenatal-genetic-diagnostic-tests

3) ACOG Committee Opinion (2020)
https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/03/carrier-screening-in-the-age-of-genomic-medicine

4) Clinical Policy: Genetic and Pharmacogenetic Testing by Centene Corporation (Reference Number: CP.MP.89; Last Review Date: 03/21)https://www.healthnet.com/content/dam/centene/policies/clinical-policies/CP.MP.89.pdf

5) Biomarker Testing for Cancer Treatment
https://www.cancer.gov/about-cancer/treatment/types/biomarker-testing-cancer-treatment

6) Center for Medicaid and CHIP Services
https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AZ/AZ-19-0004_0.pdf

7) National Comprehensive Cancer Network (NCCN) Guidelines
https://www.nccn.org/guidelines/category_1

8) The American Society of Clinical Oncology (ASCO) has developed and published clinical practice guidelines on a variety of topics, including tumor markers for breast cancer, colorectal cancer, lung cancer, and others.
https://www.asco.org/research-guidelines/quality-guidelines/guidelines/assays-and-predictive-markers

9) The National Academy of Clinical Biochemistry publishes laboratory medicine practice guidelines, including Use of Tumor Markers in Clinical Practice: Quality Requirements, which focuses on the appropriate use of tumor markers for specific cancers.
https://www.aacc.org/-/media/Files/Science-and-Practice/Practice-Guidelines/Tumor-Markers-Quality Requirements/TumorMarkers_QualityRequirements09.pdf?la=en&hash=ABC1D9C9914407CC35914F344EABCFE7DEAE311D

10) Tumor Markers in Common Use
https://www.cancer.gov/about-cancer/diagnosis-staging/diagnosis/tumor-markers-list (reviewed May 11, 2021)

11) Aetna BRCA Testing, Prophylactic Mastectomy, and Prophylactic Oophorectomy
http://www.aetna.com/cpb/medical/data/200_299/0227.html

12) AIM Specialty Health
https://aimspecialtyhealth.com/resources/clinical-guidelines/genetic-testing/

Policy 32: Regional Centers (GGRC, SARC)

Services for Persons with Developmental Disabilities

Under California law, the state's designated regional centers provide services for persons with developmental disabilities and their families to help plan, access, coordinate and monitor the services and support needed because of a developmental disability.

Persons with developmental disabilities may be eligible for regional center services if they meet the following criteria:

1. The disability is due to one of the following:
    - Intellectual disability or conditions requiring similar services
    - Cerebral palsy
    - Epilepsy
    - Autism
    - Down syndrome
    - Other disabling conditions as defined in Section 4512 of the *California Welfare and Institutions Code* https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=4512
2. The disability began before the age of 18
3. The disability is expected to continue indefinitely
4. The disability is substantially disabling for the individual

Infants and toddlers (ages 0 to 36 months) who are at risk of having developmental disabilities or who have a developmental delay may also qualify for services. The criteria for determining the eligibility of infants and toddlers is specified in *Section 95014 of the California Government Code* https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=GOV&division=&title=14.&part=&chapter=4.&article=
In addition, individuals at risk of having a child with a developmental disability may be eligible for genetic diagnosis, counseling and other prevention services. For information about these services, see Early Start. https://www.dds.ca.gov/services/early-start/

Eligibility is established through diagnosis and assessment performed by regional centers. Referrals can be made to the local regional center via telephone, fax or mail. The regional center for San Francisco County and San Mateo County is Golden Gate Regional Center (GGRC), and the regional center for Santa Clara County is San Andreas Regional Center (SARC).

The regional center primarily provides case management services to eligible individuals. A Social Worker is assigned to the member to provide counseling services and act as a client advocate to assure that services received best meet client needs. The Social Worker will have regular contact with the member and maintains a complete case record, including medical information and reports.

Some Medi-Cal members receiving regional center services may be eligible for the Home and Community-Based Waiver Program administered by the Department of Developmental

Services (DDS). These programs may be accessed based on regional center determination of client need and the availability of waiver services.

POLICY

NEMS MSO is responsible for providing all screening, preventive, medically necessary, and therapeutic covered services to members with developmental disabilities. The PCP is responsible for referring members with developmental disabilities to the local regional center for evaluation and access to non-medical services provided through the regional center, such as respite, out-of-home placement, supportive living, etc. The PCP and NEMS MSO will monitor and coordinate all medical services with the regional center staff to identify all appropriate services, including medically necessary outpatient mental health services.

The services provided by the regional center are not a part of the health plan's benefit, but will enhance the services available to eligible members. The PCP and NEMS MSO continue to provide medically necessary covered services for members eligible for regional center services. Coordination and collaboration between the PCP and the regional center, including referral to the program, are documented in the member's record.

If the member is not already receiving regional center services, the PCP shall refer a member to the local regional center, as mandated by State law, within two days of identification of the need. PCPs should document the referral in the member's medical record and notify NEMS MSO.

PCPs shall advise the parent or guardian of children over age three to make an appointment at the local regional center for intake. Appointments for children over age three must be made directly by the parent or guardian and cannot be made by a physician or staff.

PROCEDURE

PCPs maintain responsibility for basic case management for members eligible for regional center services and for requesting referrals to appropriate specialty care. As appropriate, providers will participate in the development and monitoring of the Individual Program Plan (IPP) managed by the local regional center.

Tracking Members with Regional Center Services in the UM System

The Health Plan provides ES/regional center member lists to NEMS MSO on a scheduled basis. Active ES/regional center members will be marked in the NEMS MSO UM system as regional center members (e.g., GGRC), enabling an alert to appear and notify the UM and CM staff about a member's regional center status. UM and CM staff will follow-up with members, providers, and the local regional center's case managers as needed to coordinate care.

Case Management for Members with Regional Center Services

Upon PCP request, NEMS MSO will coordinate with the local regional center to assure timely referral and assist members with developmental disabilities in understanding and accessing services made available through the program. The NEMS MSO Care Coordinator acts as a

central point of contact for questions, access and care concerns, and problem resolution. Members who are no longer eligible for regional center services will be transitioned to in-network services. The NEMS MSO Care Coordinator will assist members in the transition.

NEMS MSO Care Coordinators may provide periodic basic case management for members enrolled in regional center services to ensure members are receiving medically necessary services in a timely manner. Case management activities may include:

- Outreach to the member/family to verify status of program eligibility
- Explain reasons for referral and/or available program resources
- Educate the member/family to contact NEMS MSO should they experience difficulty in accessing or coordinating care
- Referral to NEMS MSO Complex Case Management if the member has complex medical conditions and would benefit from additional case management services

NEMS MSO will track the status of regional center members in the UM system to maintain an updated member list to ensure members receive coordinated care. If potential duplication of services is identified, the UMC/Care Coordinator will contact the case managers at the local regional center to coordinate care to prevent duplication of services.

Policy 33: Health Homes Program

The Health Homes Program (HHP) was created to coordinate the full range of physical health care services, behavioral health services, and community-based long-term services and supports (LTSS) needed by members with chronic conditions.

NEMS is a certified CB-CME to provide HHP services to Medi-Cal patients.

NEMS provides the following six core HHP services to eligible Medi-Cal members:

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and social support services.

NEMS informs contracted providers about HHP via an HHP flyer that is available to providers and members at the clinics. The flyer includes information about HHP and the referral process. Members and providers are encouraged to contact the NEMS case management team for HHP at 415-352-5179 or email at casemanagement@nems.org.

For details about HHP, please refer to the Health Homes Program Manual.

Policy 34: Hepatitis C Management

NEMS MSO follows the guidelines set forth in the DHCS "Treatment Policy for the Management of Chronic Hepatitis C" in the provision of hepatitis C virus (HCV) treatments.

POLICY

1. NEMS MSO adopts the guidelines published by the DHCS and the American Association for the Study of Liver Diseases (AASLD)
2. Utilization management protocols are medically reasonable and do not unnecessarily impede access to treatment.
3. NEMS MSO informs contracted providers of the requirement to utilize guidelines
4. NEMS MSO provides contracted providers with access to the guidelines

PROCEDURE

1) NEMS MSO adopts the AASLD guidelines set forth in the Treatment Policy for the Management of Chronic Hepatitis C. The recommended treatment regimens and durations can be accessed at the AASLD website https://www.hcvguidelines.org/

A. Pretreatment Assessment

Evaluation for advanced fibrosis using noninvasive markers and/or elastography, and rarely liver biopsy, is recommended for all persons with HCV infection to facilitate decision making regarding HCV treatment strategy and determine the need for initiating additional measures for the management of cirrhosis (eg, hepatocellular carcinoma screening).

B. Identifying treatment candidates:

a. Treatment is recommended for all patients with acute or chronic HCV infection, except those with a short life expectancy that cannot be remediated by HCV therapy, liver transplantation, or another directed therapy. Patients with a short life expectancy owing to liver disease should be managed in consultation with an expert.

b. Patient readiness and adherence:

i. Patients shall be evaluated for readiness to initiate treatment.
ii. Patients selected for treatment shall be able and willing to strictly adhere to treatment protocols prescribed by their provider.
iii. Caution shall be exercised with patients who have a history of treatment failure with prior HCV treatment due to non-adherence with treatment regimen and appointments.
iv. Patients shall be educated regarding the potential risks and benefits of HCV therapy, as well as the potential for resistance and failed therapy if medication is not taken as prescribed.

B. Other considerations

a.

b. Criteria for reauthorization/continuation of therapy:

i. Initial authorization criteria have been met

ii. Evidence of lack of adherence may result in denial of treatment reauthorization.
iii. Missed medical appointments related to HCV may result in the denial of treatment authorization.

c. Laboratory testing:
i. Documentation of baseline HCVRNA (HCV viral load)
ii. Laboratory testing and monitoring should be consistent with current AASLD guidelines.

d. Populations unlikely to benefit from HCV treatment: According to AASLD/IDSA HCV guidelines, "Patients with a limited life expectancy that cannot be remediated by HCV treatment, liver transplantation or another directed therapy do not require antiviral treatment. Patients with a short life expectancy owing to liver disease should be managed in consultation with an expert." Please refer to AASLD guidelines for more information on populations unlikely to benefit from HCV treatment. https://www.hcvguidelines.org/

e. Retreatment: Retreatment will be considered where there is evidence that such retreatment will improve patient outcomes. Please refer to AASLD guidelines for recommended retreatment regimens . https://www.hcvguidelines.org/

f. Criteria for coverage of investigational services (Title 22 § 51303):
i. Investigational services are not covered except when it is clearly documented that all of the following apply:
ii. Conventional therapy will not adequately treat the intended patient's condition.
iii. Conventional therapy will not prevent progressive disability or premature death.
iv. The provider of the proposed service has a record of safety and success with it equivalent or superior to that of other providers of the investigational service.
v. The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives.
vi. The service is not being performed as a part of a research study protocol.
vii. There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living.
viii. All investigational services require prior authorization. Payment will not be authorized for investigational services that do not meet the above criteria or for associated inpatient care when a beneficiary needs to be in the hospital primarily because she/he is receiving such non-approved investigational services.

g. Unlabeled use of medication: Authorization for unlabeled use of drugs shall not be granted unless the requested unlabeled use represents reasonable and current prescribing practices. The determination of reasonable and current prescribing practices shall be based upon:
i. Reference to current medical literature.
ii. Consultation with provider organizations and academic and professional specialists.

2. NEMS MSO ensures that UM protocols to authorize HCV treatments are medically reasonable and do not unnecessarily impede a patient's access to treatment. NEMS MSO UM collaborates with providers to obtain all necessary information to process the treatment authorization in accordance with the Health Plan's Medi-Cal turnaround time standards. The UM team uses the AASLD treatment guidelines and other UM criteria such as Medi-Cal, Health Plan and MCG criteria for decision. The UMC may refer cases to the CM team for case management services and coordination of care.

It is the Health Plan's responsibility to review authorization requests for investigational services. NEMS MSO UM will authorize investigational services if the Health Plan deems it appropriate.

3. Through the NEMS MSO provider newsletter, NEMS MSO informs contracted providers of the requirement to utilize guidelines. The AASLD guidelines and its website location will be provided on the provider newsletter.

4. NEMS MSO provides contracted providers with access to the guidelines. The AASLD guidelines and its website location will be posted on https://www.nemsmso.org/um-functions/.

References:

1. DHCS APL 18-013, August 14, 2018: Treatment Policy for the Management of Chronic Hepatitis C (Updated and Effective March 30, 2020)
2. DHCS website: http://www.dhcs.ca.gov/Pages/HepatitisC.aspx
3. AASLD guidelines: https://www.hcvguidelines.org/

Policy 35: Hospice Care

POLICY

NEMS MSO covers hospice care services for members who qualify for and choose hospice care. NEMS MSO ensures that all members who elect hospice care are provided the scope of services as defined in Health and Safety Code § 1339.44 and the California Code of Regulations, 22 CCR §51180.

PROCEDURE

I. Eligibility

A. A member is eligible for hospice program admittance when:

1. The member has a physician certified life expectancy of 6 months or less if the terminal illness follows its normal course.
2. Cure of the disease process is no longer the goal of treatment. (For specific pediatric hospice guidelines, please see section II below)
3. The primary goal for the member is to focus on comfort, pain control, and emotional, spiritual, and psychological support.
4. It is appropriate to direct treatment to improve the quality of the remaining days for the member and member's family.
5. It is agreed by the physician and member and/or member's representative that advanced technology is used solely for the purpose of sparing the patient discomfort or limitations he/she would otherwise suffer.
6. The member, member's family, and physician are all willing to participate in the program with the understanding that withdrawal is possible at any time.

B. Election of hospice care occurs when the member or member's representative voluntarily completes and signs the Hospice Election Form, indicates the election effective date, and selects a hospice provider. Signing this form indicates the member's understanding that hospice care is intended to alleviate pain and suffering, rather than to cure the disease, and that certain benefits are waived by election of this service.

II. <u>Pediatric Hospice Guidelines</u>

A. A member under 21 years of age may be eligible for hospice services concurrently with curative and palliative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018.

B. Voluntary election of hospice care does not constitute a waiver of any of the member's rights to be provided with covered services, including life-prolonging therapies related to the treatment of the member's condition for which a diagnosis of terminal illness has been made.

C. NEMS remains responsible for all medical care, whether related or unrelated to the treatment of the terminal illness, excluding care covered through California Children's Services (CCS).

D. CCS covers the non-hospice-related medical care for a CCS-eligible condition.

- NEMS MSO is responsible for the provision of all medically necessary

services until the member's CCS eligibility is confirmed by the local CCS program, and the medically necessary services are being provided under the CCS program.

III. Hospice Referral

A. Providers refer members to hospice services. NEMS MSO informs staff, network providers and other relevant programs/non-network providers, of the importance of timely recognition of a member's eligibility for hospice care services and their election of hospice care services.
B. The only requirement for initiation of out-patient hospice services is a physician's certification that a member has a terminal illness and a member's "election" of such services.

IV. Coordination of Care

A. NEMS MSO is responsible for provision and/or coordination of all covered medical services not related to the terminal condition.
B. The primary care provider (PCP) shall continue to manage the member's medical needs including both hospice related care and medical care not related to the member's terminal condition.
C. Once a member elects hospice care services, NEMS MSO network providers work with hospice care providers to facilitate the transfer of the member's services from those directed toward cure and/or prolongation of life to those directed toward palliation (except for members under age 21).
D. Ongoing care coordination is provided to ensure services necessary to diagnose, treat, and follow-up on conditions, not related to the terminal illness, will continue to be provided or are initiated as necessary.
E. Members who elect hospice care may not be disenrolled from NEMS MSO unless they move their legal residence outside of San Francisco County for SFHP members and outside of Santa Clara County for SCFHP members. See CS-06 regarding geographic disenrollment.

V. Hospice Benefits

A. An individual may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods in accordance with Section 1812(d)(1) of the SSA and Title 42, CFR, Section 418.21.
B. NEMS MSO assures hospice care services provided, to all NEMS MSO members, are at a minimum equivalent to hospice benefits provided under the Medicare program, as defined in Section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd), including:
    - Nursing care provided by or under the supervision of a registered nurse,
    - Physical or occupational therapy, or speech-language pathology services,
    - Medical social services under the direction of a physician,
    - Home health aide and homemaker services,
    - Medical supplies (including drugs and biologicals) and the use of medical appliances,
    - Physician's services,
    - Inpatient respite care provided on an intermittent, non-routine and

occasional basis for up to five consecutive days at a time in a hospital, skilled nursing, or hospice facility,
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility,
- Counseling, including dietary counseling, and
- Any other item or service specified in the care plan, which is a covered benefit.

C. Hospice is responsible for the following services, related to the terminal illness, until such time as the member revokes his/her enrollment in hospice or he/she has been discharged by the hospice provider:
   1. Room and board at licensed skilled nursing facility (SNF)
   2. Acute inpatient hospitalization when arranged by the hospice provider.
   3. Nursing facility (Level A or B) services beyond respite care limits

      Physician and/or consulting physician services not considered hospice, and when the physician is not an employee of the hospice or providing services under an arrangement with the hospice. Physician services included are:

      a.

      a. General supervisory services of the hospice Medical Director; andb. Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the hospice interdisciplinary team.

D. When a member enrolled in hospice is hospitalized for a condition related to the terminal diagnosis (e.g., uncontrollable pain) or receiving hospice care at a licensed SNF, payment for the hospitalization or room and board is a pass-through to the hospice provider, and the hospice provider pays the facility directly.

VI. Services not Covered by the Hospice Provider

A. Private pay room and board or residential care.
B. Acute in-patient hospitalization when admission is not arranged by the hospice provider and/or unrelated to the terminal illness.
C. Level A or Level B NF for issues unrelated to the terminal illness.
D. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of the hospice or providing services under an arrangement with the hospice.
E. Other necessary services for conditions unrelated to the terminal illness.

VII. Prior Authorization Requirements

A. The four levels of hospice care include:
   1. Routine Home Care
   2. Continuous Home Care
   3. Respite Care
   4. General Inpatient Care
B. Of the four levels of hospice care, only General Inpatient Care requires prior authorization. General Inpatient authorization requests are decided within 24 hours of receipt. Requests not decided within 24 hours of receipt are deemed

approved.

C. Authorization is not required for routine home care, continuous home care, or respite care levels of care, for hospice physician services, or for room and board in accordance with the All Plan Letter (APL) 13-014.

VIII. Dual Eligible Medicare/Medi-Cal

A. Primary coverage for hospice lies with Medicare for members with Medicare Part A. Following payment from Medicare, the hospice bills NEMS MSO for the co-payment amounts; the total reimbursed amount must not exceed the Medicare rate (refer to 22 CCR §51544).

B. For members with Medicare Part B only, hospice benefits are covered by NEMS MSO. No Medicare denial is required.

C. Prior authorization is not required for the hospice to bill NEMS MSO for the room and board covered by Medi-Cal while the patient is receiving hospice care services under Medicare in accordance with Title 42, CFR, 418.112 and section 1902(a)(13)(B) of the SSA.

D. NEMS MSO pays the room and board to the hospice provider, and the hospice is responsible for paying the licensed SNF.

IX. Hospice at Skilled Nursing Facilities (SNF) for Medi-Cal Members

A. Hospice care services at licensed SNF are covered services for Medi-Cal members and are not categorized as long-term care services, regardless of the member's expected or actual length of stay in a nursing facility while also receiving hospice care.

B. Admission to a licensed nursing facility of a member who has elected hospice services does not affect the member's eligibility for enrollment in NEMS MSO. Members in facility-based hospice may not be disenrolled from managed care, as described in CO-02 Members Admitted to a Lower Level of Care (LLOC) Facilities.

- NEMS MSO will not require authorization for room and board in accordance with Title 42, CFR, 418.112 and section 1902(a)(13)(B) of the SSA.

X. Member Revocation

A. A member's voluntary election may be revoked or modified at any time during an election period. A NEMS MSO member who wishes to revoke the election must personally, or through a representative, file a signed statement with the hospice revoking the individual election for the remainder of the election period. The effective date cannot be retroactive; the member also has the right to execute a new election for the remaining election periods, and to change the designation of a hospice provider once each election period.

DEFINITION

Continuous Home Care: Continuous home care, as defined in 22 CCR **§ 51180.4,** means care provided in the individual's residence, which consists predominately of skilled nursing care, for a mini mum of eight hours in a 24-hour period, for the palliation

or management of acute medical symptoms and/or when the family or caregiver is physically or emotionally unable to manage the patient's care.

General Inpatient Care: General inpatient care, as defined in 22 CCR **§ 51180.6,** means services in an acute hospital, skilled nursing facility/Level B, or a hospice facility which is organized to provide inpatient care directly, for the purpose of pain control or acute or chronic symptom management.

Respite Care: Respite care, as defined in 22 CCR **§ 51180.5,** means short-term inpatient care in an acute hospital, skilled nursing facility/Level B, intermediate care facility/Level A, or a hospice facility which is organized to provide inpatient care directly, when necessary to relieve family members or others primarily caring for the individual.

Routine Home Care: Routine home care, as defined in 22 CCR **§ 51180.3,** means care provided in the individual's residence which is not continuous care.

Terminal Illness: Terminally ill, as defined in 22 CCR §51180.2, means that an individual's medical prognosis as certified by a physician, results in a life expectancy of six (6) months or less. Health and Safety Code §1746(7)(p) expands that definition for all licensed health care service plans to include "a medical condition resulting in a prognosis of life of one (1) year or less if the disease follows its natural course. 42 CFR §418.22(b) requires that the physician certification contain the qualifying clause: "if the terminal illness runs its normal course." Pursuant to contractual requirements, plans may not deny hospice care services to members certified as terminally ill.

Reference: SFHP Policy and Procedure: Hospice Care

Policy 36: Human Breast Milk Coverage for Infants

POLICY

Medi-Cal benefits include enteral nutritional supplemental or replacement formulas when medically diagnosed conditions preclude the full use of regular food. NEMS MSO will arrange for the provision of human milk for newborns if the following criteria are met:

I. The mother is unable to breast feed due to medical reasons, and
2. The infant cannot tolerate or has medical contra-indications to the use of any formula, including elemental formulas.

PROCEDURE

If NEMS MSO receives an authorization request for human breast milk for a newborn, the NEMS MSO Utilization Management (UM) Department will review the authorization request and determine if the request meets the requirement criteria for authorization.

An authorization will be granted if both of the following criteria are met:

1. The mother is unable to breast feed due to medical reasons, and
2. The infant cannot tolerate or has medical contra-indications to the use of any formula, including elemental formulas.

The NEMS UM Department will review the authorization for medical necessity and if both criteria are met, NEMS MSO will authorize the request for human breast milk.

NEMS MSO will coordinate care with the Mother's Milk Bank in San Jose, California for the timely provision of human milk for the infant.

Policy 37: Identification of HIV/AIDS Specialists

POLICY

North East Medical Services Management Services Organization (NEMS MSO) identifies practitioners who qualify as HIV/AIDS specialists to whom appropriate members may be given a standing or extended referral when the member's condition requires the specialist's medical care.

PROCEDURE

1. NEMS MSO annually identifies or reconfirms appropriately qualified physicians who meet the definition of an HIV/AIDS specialist. The following is the definition of a HIV/AIDS Specialist:
   - Is a physician who holds a valid, unrevoked, and unsuspended license to practice medicine in the state of California and meets any one of the following criteria:
   - Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine.
   - Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties.
   - Is board certified in the field of Infectious Diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education (CME) in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to anti-retroviral therapy per year.
   - Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following:
     - In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases or 30 hours of category 1 CME in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients.
     - In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 CME in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.
2. A list of HIV/AIDS specialists is distributed to the Utilization Management Department annually.

Policy 38: Immunizations (Vaccines for Children and Public Health Programs)

Primary care physicians (PCPs) are responsible for keeping accurate and up-to-date records of immunizations administered in members' medical records. PCPs will record information received from other providers on immunizations provided to the member on an "urgent need basis" in the member's medical record.

PCPs are to facilitate appointments and administer necessary immunizations to complete the Advisory Committee on Immunization Practices (ACIP) immunization schedules, which are approved by the American Academy of Pediatrics (AAP). . Health plans require documentation of immunization status in members' medical records and use the following forms: PM 160-Information Only Form, HCFA 1500 and State Form PM 298 F2 (yellow California School Immunization Record).

PCPs are to provide parents with an immunization record and document immunizations as they are administered.

While PCPs are responsible for providing immunizations according to the ACIP recommended schedules, members may also self-refer to their local Department of Public Health (DPH) immunization clinics.

DPH is to refer members back to their PCPs in the following cases:

- A child less than six (6) months is behind in all doses of vaccines according to the ACIP immunization schedule
- A non-Medi-Cal adult requests vaccination(s) prior to travel

DPH can provide immunizations to members on an "urgent need" basis defined as:

- A child who is six months or more behind on any dose of vaccine according to the ACIP immunization schedule
- A child aged 4.5 years or more with no prior immunizations or incomplete immunizations who presents between July 1 and the starting date of his/her school and is unable to obtain an appointment with his/her PCP prior to the school start date

PCPs are encouraged to enroll in the Vaccines for Children (VFC) Program (San Francisco Bay Area VFC Program telephone: 510- 412-1608) which reimburses vaccine costs for immunizations provided to Medi-Cal patients. . This program pays for the vaccines, while NEMS MSO reimburses the administration fees.

Flu Vaccination

NEMS MSO recognizes the importance of widespread flu vaccination. NEMS MSO provides flu vaccines to its members with no cost-sharing requirement. NEMS does not require prior authorization for flu vaccination from contracted or non-contracted providers. Claims without prior authorization from non-contracted providers that include services other than flu vaccination are subject to review. NEMS MSO will provide timely reimbursement of all reasonable provider claims.

Policy 39: Initial Health Assessment (IHA), Individual Health Education Behavior Assessment (IHEBA), and Staying Healthy Assessment (SHA) Screenings

POLICY

The Staying Healthy Assessment (SHA) is the DHCS's Individual Health Education Behavior Assessment (IHEBA). Medi-Cal enrolled providers are required to use and administer the SHA to all Medi-Cal beneficiaries as part of the Initial Health Assessment (IHA) and periodically re-administer it according to screening requirements.

An IHA consists of a comprehensive history and physical examination and the IHEBA that enables the PCP to comprehensively assess the member's current acute, chronic, and preventive health needs. The IHA also helps identify members whose health needs require coordination with appropriate community resources and other agencies for services not covered by the health plan.

All new members should have the IHEBA completed within 120 calendar days of enrollment as part of the IHA. All existing members should have the IHEBA completed at the next non-acute care visit, but no later than their next scheduled health screening exam.

PROCEDURE

NEMS MSO distributes policy reminder letters to all contracted PCPs about the IHA/IHEBA requirement and assists providers in obtaining the necessary forms to perform the screenings for their members.

NEMS MSO is responsible for covering all medically necessary diagnostic, treatment, and follow-up services that reflect the findings or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. PCPs are responsible to ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

PCPs are responsible for identifying new and existing members without an IHA and establishing an outreach process to facilitate member compliance with IHA and IHEBA participation, including:

1. At least three documented outreach attempts that demonstrate unsuccessful efforts to contact a member to schedule an IHA
2. Contact methods must include at least one telephone and one mail notification and may include:
    a. New member enrollment package/materials
    b. IHA reminder messages
    c. Member newsletters
    d. Member website/portal
    e. Phone calls
3. Documentation of all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed

PCPs must maintain proper documentation in a member's medical record, including:

1. Missed appointments
2. Attempts for follow-up
3. Monitoring and intervention process to ensure appropriate utilization of IHA/IHEBA standards

PCPs must ensure that the completed IHA and IHEBA tools are contained in the member's medical record and available during subsequent preventive health visits.

NEMS MSO performs periodic review of member records to ensure that providers are completing the IHA/IHEBA as required. Providers who need assistance with obtaining the necessary forms may reach out to NEMS MSO Provider Relations Department.

Policy 40: Lactation Support Services

NEMS MSO provides lactation support services such as breast pumps and breast pump supplies, lactation counseling, and human breast milk for medical conditions of the mother or of the child that interfere with the establishment and maintenance of lactation (refer to Policy and Procedure on Human Breast Milk Coverage for Infants).

POLICY

1. NEMS MSO covers lactation support services that may be purchased or rented if medically necessary.
2. NEMS MSO does not cover lactation support services for the purpose of returning to work or other non-medical needs.

PROCEDURE

I. Prior Authorization

- Manual and electric breast pumps and pump supplies do not require prior authorization
- Hospital grade (multi-user) electric breast pumps (HCPCS code E0604) are covered when medically necessary for daily rental only and requires prior authorization.

II. Eligibility

The NEMS MSO UMC assists the provider, when requested, to determine eligibility.

- If the member's eligibility is on hold, the UMC assists the member to obtain lactation support services through the Women, Infants and Children Program (WIC) and the Department of Public Health (DPH) until eligibility is established.

III. Documentation When TAR is Required

A TAR is required for hospital grade (multi-user) electric breast pumps. The UM team determines that the item is medically necessary if the following criteria are met:

- If direct nursing at the breast is established during the neonatal period (the period immediately following birth and continuing through the first 28 days of life) and nursing is interrupted, medical necessity for code E0604 is defined as the existence of any of the following medical conditions:
  - The mother has a medical condition that requires treatment of her breast milk before
  - infant feeding; or
  - The mother is receiving chemotherapy or other therapy with pharmaceutical agents that render her breast milk unsuitable for infant feeding; or
  - The infant developed a medical condition or requires hospitalization that precludes direct nursing at the breast on a regular basis.

- If direct nursing at the breast is not established during the neonatal period, medical necessity for code E0604 is defined as the existence of any of the following medical

conditions:

- Any maternal medical condition that precludes direct nursing at the breast; or
- The infant has a congenital or acquired neuromotor or oral dysfunction that precludes effective direct nursing at the breast; or
- The infant has a congenital or acquired condition that precludes effective direct nursing at the breast; or
- The infant continues to be hospitalized and the mother is no longer an inpatient.

Policy 41: Language Assistance Program (LAP)

Language assistance services are provided free of charge to members in the requested language through bilingual staff or an interpreter. Language assistance service includes interpretation services and translation services for non-standardized vital documents for members with limited English proficiency (LEP).

POLICY

1. Member's Right to Interpreter Services:
    - Language assistance services must be provided free of charge, accurately, timely, and protect the privacy and independence of the individual with LEP.
    - Language services are provided to members in the requested language through bilingual staff or an interpreter.
    - Friends or family members are not used as interpreters unless specifically requested by the member.
    - Member may request face-to-face or telephone interpreter services.
    - Member may receive informing documents translated into threshold languages.
    - Member may file grievances or complaints if linguistic needs are not met.
    - Providers must document preferred language and requests for language and/or interpretation services by a non- or limited English proficient person in the medical record.
    - Providers must also document member's refusal to accept the services of a qualified interpreter.
    - Members requesting interpreter services will be offered/matched with the same interpreter at subsequent medical visits to ensure continuity of care to the extent possible.
    - Telephonic interpreter services are available to members on a 24-hour basis.
2. NEMS MSO offers a qualified interpreter to an individual with LEP when oral interpretation is a reasonable step to provide meaningful access for the individual with LEP. NEMS MSO interpreters are evaluated for their interpreter skills and are required to pass the Language Line Interpreting Language Test.

3. NEMS MSO shall use a qualified translator when translating written content in paper or electronic form.
4. Interpretation services from a qualified interpreter shall be provided to LEP members. This service shall be provided free of charge, accurately, timely, and protect the privacy and independence of the individual with LEP. Interpretation services will be provided orally either over-the-phone or in-person.

PROCEDURE

1. NEMS MSO staff identifies the non-English languages spoken by members from the following source:
    - Health Plan eligibility verification file/website

- The Utilization Management data system
- Member's medical records
- Member or family
- Member's providers

2. NEMS MSO provides cultural and linguistic services free of charge to members. Members and providers can request interpretation services by phone, fax or email. Providers may fill out the Interpretation Services Request Form available on the NEMS MSO website at https://www.nemsmso.org/interpretation-services/

A. Interpretation Services

a. In-Person Interpretation Services *(Cantonese & Mandarin Only)*

- MSO Interpreter receives a request for interpretation services
- MSO Interpreter screens request to ensure that it warrants in-person interpretation service
    - *Does office have Cantonese/Mandarin speaking staff?*
    - *Does office have landline in exam room? If so, would they like to opt for over-the-phone interpretation?*
- Once an in-person interpretation service is warranted, the MSO Interpreter saves the request, logs the request, and adds it to the calendar.
- MSO Interpreter notifies patient that they will meet them at the lobby.
- On date of appointment, MSO Interpreter will meet patient at the lobby of the provider's office.
- If interpretation at a follow-up appointment is needed at the office, the information is noted and added to the log and calendar upon returning to the MSO office.
- MSO Interpreter completes the log.

b. In-Person Sign Language
- Call Language Line vendor to request a sign language interpreter

c. Over-the-Phone Interpretation Services

For Immediate Call-Ins:

- Outside provider/patient calls in
- MSO staff collects patient information
    - Patient ID number, name & date of birth
    - Determine the language needed
    - General understanding of situation and need of interpretation service (for logging purposes)
- If MSO has Interpreter of requested language in-house:
    - MSO Staff will call MSO Interpreter and
        - Explain the situation to the interpreter and who they will be interpreting for

- If MSO Interpreter is out of the office, staff calls Language Line (go to step 4a).
- If Other Languages:
  - MSO Staff calls Language Line and
    - Collects interpreter number
    - Explain the situation to the interpreter and who they will be interpreting for
    - If patient is calling, have interpreter ask them to put phone on speaker
  - Warm transfer the interpreter to the caller
- MSO Staff completes the log

For Scheduled Calls:

- ***For In-House Languages:***
  - MSO Interpreter receives request for over-the phone interpretation services
  - Interpreter confirms with requester. Interpreter saves the request, adds it to the calendar, and logs the request.
  - Interpreter calls requester on date and time of request.
  - Interpreter completes the log
- ***Other Languages:***
  - MSO Provider Relations (PR) receives a request for over-the-phone interpretation services
  - MSO PR confirms with requester. PR saves the request, adds it to the calendar, and logs the request.
  - MSO PR calls requester on date and time of request and connects him/her to an interpreter at Language Line.
  - MSO PR completes the log

1. Translation Services

1. NEMS MSO provides written information available in the prevalent non-English languages particular to the NEMS patient population, e.g., health education material. NEMS MSO determines language threshold of its member population following the Department of Managed Health Care's guidelines. The threshold language is a population group with primary language other than English and that meet a numeric threshold of 3,000 or fivepercent (5%) of the eligible beneficiary population, whichever is lower.

2. NEMS UM staff sends written notification called the Notice of Action (NOA) to members and practitioners, as appropriate, of the reasons for each denial, including specific utilization review criteria or benefits provisions used in the determination. NOA, including the clinical rationale, is provided in a member's preferred language. A Non-Discrimination Notice and taglines with language assistance information are sent with the NOA. The taglines inform members of the availability of language assistance services. If a member speaks a language

other than English, language assistance services, free of charge, are available by calling 1(415)-391-9686 ext. 8160 (TTY: 1-800-735-2929).

3. When NEMS MSO staff receives a request for translation, the staff refers the request to the Provider Relations (PR) team. The PR team directs/forwards all translation requests to the Health Plan by calling the Health Plan's Member Services number.

4. The PR team tracks member requests for translation services on an Excel log. The log includes the following items:

- Date and time the request for translation of vital document was received
- Date and time the request for vital document was forwarded to the Health Plan

5. The PR team follows the timeliness standards for forwarding the translation requests or supporting documents related to healthcare services to the Health Plan within one business day of receipt for urgent requests and within two business days of receipt for non-urgent requests.
6. All NEMS MSO staff receive cultural and sensitivity training through on-line Relias Learning annually. The education and training documents include the following items.

- The Health Education Department creates the training materials that include the Health Plan's LAP materials
- Human Resources Department keeps NEMS staff completion records
- The appropriate phone number and name of the Health Plan Department responsible for coordinating interpretation services is made available to the PR staff

Reference:
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-004.pdf

Policy 42: Local Education Agency

The San Francisco Unified School District's (SFUSD) Local Education Agency (LEA) provides special education services for eligible children 36 months or older. Referrals by the primary care provider (PCP) or NEMS MSO Case Manager can be made directly to the SFUSD Special Education Services office at (415) 759-2222 or Early Childhood Special Education Services at (415) 401-2525 x1101 or by email at ecreferrals@sfusd.edu for children ages 3-5. If members want to self-refer, they should contact their school principal to initiate an assessment or SFUSD directly.

For children who are in the Early Start program, SFUSD receives notification from Golden Gate Regional Center (GGRC) of a potentially eligible child 90 days before the child's third birthday. The parent/guardian, GGRC service coordinator, and a school district representative will meet and discuss the referral and assessment process to determine eligibility and in-school services. The member must meet the requirements for an Individualized Education Program (IEP) or 504 Plan. The member is also assessed for continued services through the Lanterman program at GGRC.

PCPs may also authorize SFUSD to perform CHDP assessments for health plan members. If the member fails more than two (2) visits with his/her PCP for CHDP assessment, or the PCP is unable to provide an assessment within sixty (60) days of SFUSD referral, then SFUSD is authorized to perform a CHDP assessment.

The Santa Clara County Office of Education's (SCCOE) Special Education Department provides a variety of services for children and students with severe or low-incidence disabilities through instructional programs divided into Early Education (birth to age 3), preschool, elementary, secondary, and post-senior. Referrals by the PCP or NEMS MSO Case Manager can be made to the SCCOE Special Education Office at (408) 423-2087 or by email at spedoffice@scusd.net. Members can also self-refer by contacting the SCCOE directly.

POLICY STATEMENT

1. NEMS MSO members in the SFUSD and Santa Clara Unified School District (SCUSD) are eligible for services under the LEA in the school special education program if they qualify through their assessment and IEP.

2. The LEA provides services to all eligible students in the LEA setting during the operative period of the LEA, which is the school year. LEA services do not require reimbursement from managed care contracts. LEA services include:

- Nutritional assessment and non-classroom nutritional education
- Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen test
- Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques
- Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with norms for age and background
- Psychosocial status assessment consisting of appraisal of cognitive, emotional, social,

and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations
- Health education and anticipatory guidance appropriate to age and health status
- Speech services
- Physical and occupational therapy
- Medical transportation
- School health aides

3. Members requiring services may self-refer to the LEA, or the member may be referred by their PCP, clinic, or medical group utilization/case management staff. The Early Start Program, local Regional Centers and California Children's Services may also identify and refer eligible members.

4. The eligibility criteria for receiving LEA services are as follows:
- Member must be a San Francisco resident (proof of residency is necessary at application time) for SFUSD and a Santa Clara County resident (proof of residency is necessary at application time) for SCUSD.
- Member accessing care within the PreK unit must be ages 3-5, although members who are age 2 should still be referred for early assessment and will be placed at age 3.
- Member does not need to be enrolled in school.

5. Once a referral is made to the LEA, the member (or parent/guardian) is sent an application packet to be completed and returned to the LEA.

6. Within fifteen (15) days of receipt of the completed packet, the LEA will contact the member (or parent/guardian) to schedule an appointment for assessment. Following assessment, the LEA will determine placement for services and develop an IEP for the member.

7. NEMS MSO shall ensure that the member's PCP cooperates and collaborates in the development of the IEP or the Individual Family Service Plan (IFSP).

8. NEMS MSO shall provide case management services and care coordination to ensure the provision of all medically necessary covered diagnostic, preventative and treatment services identified in the IEP with PCP participation.

9. The NEMS MSO is not responsible for authorizing LEA provided services.

10. As the LEA provides services during the school year only, NEMS MSO will authorize and provide medically necessary services during the summer months.

Policy 43: Mail Processing and Distribution

PURPOSE

To ensure that mailing is handled appropriately and safely in a timely manner.

POLICY

1. NEMS MSO has established procedures to ensure an appropriate, secure, and safe method of handling all mail received at its clinics and delivered to the local post office or other shipping services. Postage and delivery are intended for mail associated with NEMS MSO business only.

2. Mail is picked up and sent out every day during business hours of Monday to Friday, except holidays.

3. NEMS MSO will not accept or process incoming or outgoing personal mail for staff, including packages. NEMS MSO is not liable for any personal mail or packages.

PROCEDURES

1) Processing of Incoming Mail - Regular Mail

Regular incoming mail that is received from the United States Postal Service (USPS) are received daily from Monday to Friday. The mail will be sorted, opened, and stamped with the date of receipt. In the event that the mail arrives after 3:30 PM, mail from that day will be sorted quickly for any time-sensitive or urgent mail and distributed the same day. The remaining mail may be distributed with the following day's mail.

Mail received on Saturday will be processed on Monday. Mail will be sorted, opened, and stamped with the date of receipt.

- Staff will check to see if each piece of mail is properly addressed to NEMS MSO and to a NEMS MSO employee.

- For any mail received that is addressed to a former NEMS MSO employee:
    - Open the mail unless stated "Confidential"
    - Any mail regarding patient records, clinical or radiology tests/exams/results or marked as "Confidential" should be forwarded to the Health Information Services (HIS) Department
    - Any mail regarding patient claims should be forwarded to the Claims Department

- For any mail received that is addressed to a former NEMS MSO employee:
    - Cross off all bar codes on the front and back of the envelope
    - Cross off address, city, state, and zip code on the front of the envelope
    - Write "Return to sender" and "No such person" on the front of the envelope
    - Drop off to post office to be returned to sender

- Mail that is addressed to a non-NEMS address:

- Cross off all bar codes on the front and back of the envelope
- Drop off to post office to be redelivered to correct address

- Any mail labeled "Personal & Confidential," "Confidential," or addressed to the President & Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Strategy Officer (CSO), Chief Medical Officer (CMO), ADP/Accounting Manager/Payroll Manager, or the Human Resources Department should not be opened but should be stamped with the date of receipt on the envelope and given to the recipient directly (or via Interoffice Mail). If using Interoffice Mail, the Provider Relation Coordinator calls the Executive Assistant or the Human Resources Department, respectively, to alert them of Interoffice Mail to be delivered.

- All mail should be stamped on the envelope and on the front of the first page of each document on the bottom right or left corner with a stamp indicating the date of receipt by NEMS MSO. If there is no room on the bottom right or left corner, stamp the top of the page instead. If there is no room to place a stamp on the front page without stamping over printed or written information, stamp the back page instead.

    - If the first page contains an address only, stamp the front of the second page instead following the guidelines above.

- MSO MSO claims and official documents, such as Birth or Death Certificates from the Public Health Department, must be stamped on the back page only.

2) Processing of Outgoing Mail – Regular Mail

All outgoing mail will be reviewed, sorted, sealed, and metered with the proper amount of postage before being sent to the post office. The Provider Relations Coordinator handles all outgoing mail except outgoing mail for Utilization Management. The MSO Utilization Management Coordinators (MSO UMC) are responsible for sending outgoing mail for the UM Department. The outgoing mail includes approval and denial letters. The MSO UMC uses envelopes with the word "Confidential" stamped on mail with Personal Health Information.

The MSO UMC drops off outgoing UM mail at the USPS mail collection box every day, Monday to Friday during business hours. The MSO UMC will take urgent mail to the USPS post office Monday to Friday during business hours if the mail needs immediate attention. The MSO UMC properly prepares UM outgoing mail, making sure to include the return address with the sender's name and department; checking for the proper mailing address; correct statement is stamped on the envelope; and preparing any certified mail or return receipt forms.

After the UMC mails written notifications to members and providers, the UMC documents in EZCAP the date and time the written notification was mailed.

Letters are mailed out by UMC the same day they are generated. UMC notifies the MSO Clinical Operation Manager if letters cannot be mailed out the same day they are generated. The MSO Clinical Operation Manager finds the root cause of non-compliance and takes corrective actions as needed.

3) Mailing with Protected Health Information (PHI)

All outgoing mail containing protected health information (PHI) are marked as "confidential" on the envelope and sent in a sealed envelope. PHI is any information about health status, provision of heath care, or payment for health care that can be linked to a specific individual. Examples of mailings with PHI are Utilization Management's Notice of Action letters, Claim's Explanation of Benefits, and Case Management's patient outreach letters, etc. Staff who are sending out the PHI are responsible for stamping "confidential" on the envelope and sealing the envelope.

4) Mailing Statements on Envelopes for Medicare Beneficiaries

All mail sent to Medicare beneficiaries should include one of the four mailing statements below on the front of the envelope to identify the type of plan mailing:

- Advertising pieces – "This is an advertisement"
- Plan information – "Important plan information"
- Health and wellness information – "Health or wellness or prevention information"
- Non-health or non-plan information – "Non-health or non-plan related information"

The above mailing statements may not be modified and must be used verbatim.

If the mailing is not advertising or a health and wellness mailing, but is related to a beneficiary's plan, the mailing should be categorized as a plan information mailing.

NEMS MSO will ensure the organization name and logo is included in every mailing to current and prospective enrollees, either on the front of the envelope or on the mailing itself if no envelope is being sent.

Policy 44: Major Organ Transplants

This policy applies to major organ transplants which include bone marrow, heart, liver, lung, heart/lung, small bowel, combined liver and kidney and combined liver and small bowel. Renal and corneal transplants are not considered major organ transplants. NEMS MSO covers renal and corneal transplants when medically necessary for a Health Plan member.

POLICY

1. NEMS MSO follows the Health Plan transplant contract and criteria.
2. NEMS MSO notifies the Health Plan of all transplant cases and all transplants related investigational/experimental services.
3. Health Plan members who are eligible and pre-authorized for major organ transplants are disenrolled from managed care Medi-Cal into fee-for-service Medi-Cal.
4. NEMS MSO is responsible for the costs of covered medical care, including the costs of transplant evaluation, organ acquisition and bone marrow search, until the effective date of disenrollment.

PROCEDURE

NEMS Utilization Management (UM) staff will follow the following procedure for major organ transplants:

1. Notification to Health Plan of all transplant cases and all transplants related investigational/experimental services
   - The NEMS UMC notifies the Health Plan of any potential transplant within 1 business day (even when in testing/evaluation phase) to determine Centers of Medical Excellence/Plan approved Transplant Center network use.
   - Health Plan's Transplant Case Management Department is notified of all transplant related admissions within 2 business days.

2. The NEMS UMC refers the case to the Nurse Case Manager for case management. The NEMS UMC, with the assistance of the Nurse Case Manager, reviews the request for transplant-related services. The following are the responsibilities of the NEMS UMC:
   - Issue the pend/deferral letter if clinical information is missing
   - Advise members regarding the use of Centers of Medical Excellence
   - Issue denial letters for benefit limitation
   - Document concurrent review, discharge planning and member needs
   - Coordinate the care for the member and communicate with the Health Plan's Transplant Case Management Department
   - Notify member and provider of the approval for the actual transplant and the transplant admission after medical review by the Health Plan
   - Provide referrals and authorizations for all pre- and post-transplant services
   - Notify the Health Plan's Transplant Case Management Department of any issues for assistance.
3. The NEMS UMC coordinates disenrollment with the transplant center and the Health Plan. If the physician at the transplant center considers the member a suitable candidate, s/he submits a prior authorization request to the Medi-Cal Field Office, 185 Berry St., Suite 290, SF, 94107. Phone (415) 904-9600, Fax (415) 904-9753.

4. If a prior authorization is granted, the transplant center and the NEMS UMC coordinate the submission of a disenrollment form to the Health Plan and/or the transplant authorization to Health Care Options (HCO). The effective date of disenrollment will be retroactive to the beginning of the month in which the transplant is approved. All services provided during that month are billed fee for service.
5. NEMS MSO provides all medically necessary care to the member until disenrollment is effective and assists with the transition to fee-for-service Medi-Cal, including the transfer of records.

Policy 45: Mastectomy Coverage

POLICY

NEMS MSO allows the physician in consultation with the patient to determine the appropriate length of stay for mastectomy and lymph node dissection. Prior authorization of length of stay is not required. Length of stay for mastectomy is not subject to prior authorization procedures.

NEMS MSO provides coverage for reconstructive surgery and all follow-up care deemed necessary by the attending physician. This includes:

- all complications from mastectomy, including lymphedema
- Prosthetic devices and reconstructive surgery for the diseased breast and prosthetic devices and reconstructive surgery for the healthy breast if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance.

NEMS MSO includes a notice of this coverage in the health plan's evidence of coverage.

DEFINITIONS

"Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

"Prosthetic devices" means the provision of initial and subsequent devices pursuant to an order of the patient's physician and surgeon.

Policy 46: Member Transition from Fee-For-Service to Medi-Cal Managed Care

POLICY

Members that transition into a Medi-Cal Managed Care Plan (MMCP) have the right to request Out-of-Network (OON) and Continuity of Care (COC) in accordance with State law and the Managed Care Plan (MCP) contract, with some exceptions. All NEMS MSO members with pre-existing provider relationships who make a continuity of care request to NEMS MSO will be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider.

PROCEDURE

A member may request continued care from a provider, including a hospital, if at the time of enrollment, the member was receiving care from a non-contracted provider for any of the following conditions:

- Treatment for acute conditions
- Serious chronic conditions for up to 12 months from the effective date of coverage
- Pregnancy, except during the first and second trimester periods, but including immediate post-partum period
- A newborn child, in the first 30 days, under mother's enrollment
- A terminal illness for the duration of the terminal illness, on a case-by-case basis
- A surgery or other procedure that has been authorized by NEMS MSO and documented to occur within 180 days of the contract termination or within 180 days of the effective coverage under the health plan

NEMS MSO provides authorization for this care under the following circumstances:

- The care from the non-contracted provider would not be covered by any other health plan offered to the member
- The services for the acute condition are otherwise covered services under the Evidence of Coverage when provided by medical group providers

NEMS MSO is not required to provide coverage if:

- The non-contracted provider does not accept the same contract terms/Medi-Cal rates of participating providers
- The services are not otherwise covered by the health plan
- The new member was offered a comparable in-network option
- The new member had the option to continue with a previous plan and voluntarily chose to change plans

Members may transition into an MMCP from one of the following programs:

- Medical Exemption Request (MER)
- Seniors & Persons with Disabilities (SPD)
- Other Targeted Low-Income Children (OTLIC)
- Covered California
- Behavioral Health Treatment for members under the age of 21
- Health Homes Program

- Pediatric Palliative Care Waiver
- Pregnant and Post-partum members

NEMS MSO will process OON and COC requests within 5 business days of receipt of request and complete them within 30 calendar days. When the medical condition requires more immediate attention, NEMS MSO follows the Health Plan's Medi-Cal TAT Standards.

Policy 47: Non-Emergency Medical Transportation (NEMT)

PURPOSE:	To provide non-emergency medical transportation (NEMT) services to Medi-Cal Managed Care members at no cost.
Application:	This policy and procedure applies to all Medi-Cal Managed Care members.

POLICY:

Non-emergency medical transportation (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.

1. North East Medical Services (NEMS) MSO provides 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. NEMS MSO provides NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. NEMS MSO shall also ensure door-to-door assistance for all members receiving NEMT services.

2. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a licensed skilled nursing facility or an intermediate care facility. NEMS MSO authorizes, 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 prior authorization.

3. NEMS MSO provides transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, NEMS MSO may arrange NEMT for a minor who is unaccompanied by a parent or a guardian. NEMS MSO must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's services. NEMS MSO ensures that all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

4. NEMS MSO provides ambulance, litter van, wheelchair van and air transportation 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.

PROCEDURES:

The Utilization Management (UM) team ensures that NEMT services are appropriately authorized, and the Care Coordination (CC) team follows up with providers and members to ensure NEMT services are provided. The following are the procedures:

A. Prior Authorization for NEMT Services:

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 care, to a skilled nursing facility or an intermediate care facility. The UM team reviews the following items for prior authorization:

1. NEMT service is ordered in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider.

2. Provider documents the medical necessity on the Treatment Authorization Form (TAR) to indicate the appropriate level of service. Members/providers can request a TAR form from NEMS MSO by telephone, electronically, or in person. All NEMT TAR forms must include, at a minimum, the components listed below:

a) Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate with assistance or be transported by public or private vehicles
b) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months
c) Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport)
d) Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested

Providers are not required to submit TARs when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a licensed skilled nursing facility or an intermediate care facility.

3. The UM team reviews the member's medical and physical condition and determines that transportation by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care.

4. The UM team evaluates and authorizes the lowest type of NEMT transportation that is adequate and appropriate for the member's medical needs. One of the four modalities of NEMT transportation is authorized when the conditions are met:

a) NEMS MSO provides **NEMT ambulance services** under the following conditions:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation
    - Transfers from an acute care facility to another acute care facility

- Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use)
- Transport for members with chronic conditions who require oxygen if monitoring is required

b) NEMS MSO provides **litter van services** when the member's medical and physical condition do not meet the need for NEMT ambulance services, but meet both of the following:
   - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport
   - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance

c) NEMS MSO provides **wheelchair van services** when the member's medical and physical condition do not meet the need for litter van services, but meet any of the following:
   - Renders the member incapable of sitting in a private vehicle, taxi. or other form of public transportation for the period of time needed to transport
   - Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation
   - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance

   Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed TAR form:
   - Members who suffer from severe mental confusion
   - Members with paraplegia
   - Dialysis recipients
   - Members with chronic conditions who require oxygen but do not require monitoring

d) NEMS MSO provides **NEMT by air** only under the following conditions:
   - When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

B. Care Coordination for NEMT Services:

The Case Management (CM) team coordinates NEMT services to ensure that the transportation is set up according to the member's needs, the member is transported as planned, and future transportation needs are met. The CM team coordinates NEMT services in a timely manner to make sure that DHCS' timely access standards are met.

1. The CM team assesses the member's needs for NEMT services to ensure the appropriate NEMT services are provided to the member. The member's transportation is assessed and set up accordingly, taking the following items into consideration:

- Time, date, and type of the medical appointment
- Member's need for language assistance
- Member's mobility - ability to walk, wheelchair-bound, or bed-bound
- Transportation modality (ambulance, litter van, wheelchair van or air) that is authorized is appropriate for the member's medical condition
- Special requests or instructions for the driver
- Age of member – minors will require parental consent to ride alone
- Member traveling alone or with company
- Member's need for a return ride

2. The CM team coordinates with the hospital discharge planner, provider, transportation agency, member, and family to ensure the member receives transportation services as planned.

3. The CM team evaluates the member's future transportation needs, follows up with the NEMS UM team for authorization, and arranges for appropriate NEMT services for upcoming medical appointments/services.

Reference: DHCS APL17-010 Non-emergency Medical and Non-medical Transportation Services

Policy 48: Non-Physician Medical Practitioners (NP/PA)

NON-PHYSICIAN MEDICAL PRACTITIONERS

Non-Physician Medical Practitioners (NPMP) with a valid, current license or certificate from the State of California may serve as the provider of primary care services for health plan members under these conditions:

The scope and requirements of practice for NPMP providing primary care services for health plan members are established by the Board of Registered Nursing or the Division of Allied Health Professionals of the California Medical Board. They include supervision by a licensed physician, who has a contract with the medical group. Supervision may be direct or include the use of medical policies and protocols established by the physician.

The supervising physician does not have to be physically present when the NPMP is seeing patients but must be available either on-site or by telephone.

The supervising physician will complete the provider information letter for each NPMP in accordance with CCR, Title 22, Section 5 1 240(a)(1) through (7) and will report any changes to DHS within 30 days. The provider information letter is effective for a period of 12 months and reviewed by NEMS MSO at the annual credentialing audit.

A NPMP Protocol establishes the scope and limitations of services to be provided by the NPMP, including the following:

- Standing orders that will be kept on file at the supervising physician's office/clinic
- Guidelines as required by Title 16. Section 1470 for registered nurses, and Title 16. Section l399.541 for Physician Assistants
- Physician assistants must have all progress notes co-signed as required by the state for the scope of practice for physician assistants.

Supervisor Requirements

The designated physician supervisor and a designated alternate physician supervisor must pose a valid Physician and Surgeon's license. In addition, the supervising physician must also maintain:

- For Nurse midwives --A current practice in obstetrics
- For Physician Assistants --Approval of the Division of Allied Health Professionals of the California Medical Board

Supervisory physicians may not supervise or oversee greater than the following full-time equivalent NPMPs:

- Four Nurse Practitioners
- Three Nurse Midwives
- Two Physician Assistants

Policy 49: Obstetrician/Gynecologist (OB/GYN) as PCP

POLICY

Members have the option to seek primary care physician (PCP) services directly from a participating Obstetrician/ Gynecologist (OB/GYN).

DEFINITION

PCP is a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referrals for specialty care. This means providing care for the majority of healthcare problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues. A PCP shall be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

PROCEDURE

Members are allowed the option to seek PCP services directly from a participating OB/GYN. OB/GYN are eligible primary care physicians, provided they meet the health plan's eligibility criteria for all specialists seeking PCP status. The eligibility criteria may include, but are not limited to the following:

- Assuring reasonable access and availability to primary care services
- Providing all preventive care and Child Health and Disability Prevention Program (CHDP) and Early Periodic Screening Diagnosis and Treatment (EPSDT) required services
- Providing access to urgent care
- Providing 24-hour coverage for advice and referral to care
- Making appropriate referrals for specialty care
- Providing coordination and continuity of care after emergency care, out-patient, in-patient, and tertiary care referrals.
- Providing referral, coordination, and continuity of care for members needing mental/behavioral health services, drug and alcohol detoxification and treatment services, or referrals for seriously medically impaired and seriously emotionally disturbed members to mental health services
- Providing referral, coordination, and continuity of care for members requiring Direct Observed Therapy for uncontrolled tuberculosis
- Providing referral, coordination, and continuity of care for members requiring services from California Children's Service (CCS), Early Start, local Regional Center , and Local Education Agency (LEA)
- Providing referral, coordination, and continuity of care for members requiring hospice care
- Case managing members or referring members for case management services as necessary
- Requesting authorizations for specialty care or services as necessary from the medical group or outside the medical group's network as necessary
- Communicating authorization decisions to the member
- Assisting the member in making appointments or other arrangements for specialty care or procedures

- Tracking and following up on referrals that are made
- Arranging transfer to a network hospital once the member is medically stable

Policy 50: Palliative Care

POLICY

NEMS MSO authorizes palliative care services, when medically necessary, to Medi-Cal members who meet DHCS's minimum eligibility criteria for palliative care. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services and does not affect a member's eligibility to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

PROCEDURE

Eligibility Criteria

Primary care physicians (PCPs) identify members who meet palliative care requirements and submit referrals for palliative care services to NEMS MSO. Palliative care referrals are reviewed to determine if the member meets all of the eligibility criteria and are authorized as appropriate. NEMS MSO provides care coordination to ensure the member can access these services.

Members of any age are eligible to receive palliative care services if they meet all of the general eligibility criteria and at least one of the four disease-specific eligibility criteria.

A. General Eligibility Criteria:
    1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
    2. The member has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
    3. The member's death within a year would not be unexpected based on clinical status.
    4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
    5. The member and, if applicable, the family/member-designated support person, agrees to:
        a) Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department, and
        b) Participate in Advance Care Planning discussions.

B. Disease-Specific Eligibility Criteria:
    1. Congestive Heart Failure (CHF): Must meet (a) and (b)
        a) The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's heart failure classification III or higher; and

b) The member has an ejection fraction of less than 30% for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)
    a) The member has a forced expiratory volume (FEV) of 1 less than 35% of predicted and a 24-hour oxygen requirement of less than 3L per minute; or
    b) The member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.
3. Advanced Cancer: Must meet (a) and (b)
    a) The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    b) The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver Disease: Must meet (a) and (b) combined or (c) alone
    a) The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    b) The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    c) The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria below and may be eligible for palliative care and hospice services concurrently with curative care. The member must meet (a) and (b) listed below:

a) The family and/or legal guardian agree to the provision of pediatric palliative care services; and
b) There is documentation of a life-threatening diagnosis. This can include but is not limited to:
    1. Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
    2. Conditions requiring intensive long-tern treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
    3. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
    4. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequalae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

NEMS MSO will periodically assess the member for changes in the member's condition or palliative care needs. Palliative care may be discontinued if it is no longer medically necessary or no longer reasonable.

For children who have an approved CCS-eligible condition, CCS remains responsible for medical treatment for the CCS-eligible condition, and NEMS MSO is responsible for the provision of palliative care services related to the CCS-eligible condition.

Palliative Care Services

NEMS MSO authorizes palliative care services when a member meets the minimum eligibility criteria for palliative care. Palliative care includes the following services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

1. Advanced Care Planning
2. Palliative Care Assessment and Consultation
3. Plan of Care
4. Palliative Care Team
5. Care Coordination
6. Pain and Syndrome Management
7. Mental Health and Medical Social Services

Reference:

Department of Health Care Services All Plan Letter 18-020, December 7, 2018

Policy 51: Pended Request and Notification

Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the member or the member's provider requests an extension, or NEMS MSO can provide justification upon request by the State for the need for additional information and how it is in the member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

POLICY

1. NEMS MSO may extend decision timeliness if the pend reasons are appropriate as outlined in this policy.
2. NEMS MSO follows the timeliness requirement for making pending decisions.
3. Notification to members and providers should include the elements listed in this policy.
4. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

PROCEDURE

1) The NEMS MSO Utilization Management Coordinator (UMC) requests additional information from the requesting provider/PCP when medical information is missing from the TAR.
2) The UMC confers with the NEMS MSO physician reviewer if additional medical information is not received. Only a NEMS MSO physician reviewer can make a decision to pend the case.
3) Benefit or contractual clarifications are not reasons to pend a request. Appropriate reasons for pending requests may include:
    - Information was requested but not received
    - Consultation by an expert reviewer is required - Expert reviewer is a person in the appropriate specialty, who can provide medical review and recommendations. If an appropriate specialty is not available in the NEMS MSO provider network, NEMS MSO sends the case to an external peer review entity for review
    - Additional examinations or tests are required
4) If NEMS MSO cannot make a decision for prospective or continued stay reviews within the required time frames due to not receiving all of the requested necessary information, NEMS MSO immediately notifies the health care provider and the member in writing. NEMS MSO sends such notification upon the expiration of the required five (5) business day time frame or as soon as NEMS MSO becomes aware that they will not be able to meet the required five (5) business day time frame, whichever occurs first.
5) The UMC sends written notifications to notify the member and provider that more information is needed to make a decision. The notification include the following items:
    - Information was requested but not received
    - Consultation by an expert reviewer is required, if applicable

- Type of expert reviewer required, if applicable
- Additional examinations or tests are required
- Time frame for submitting the information
- Expected date of decision

6) Upon receipt of all necessary information, NEMS MSO renders a prospective review determination within the required five (5) business day timeframe and a concurrent review decision within 24 hours.
7) If no information is received within the 14 calendar days (from the date of receipt of the TAR) given to the provider to supply the information, the NEMS MSO physician reviewer reviews and denies the case.
8) The UMC notifies the requesting provider initially by telephone, fax or email and then in writing within 24 hours of making the decision, but not to exceed 14 calendar days from the day of receipt of the TAR. The UMC notifies the member in writing within 2 business days from the decision, but not to exceed 14 calendar days from the day of receipt of the TAR.
9) If the case is denied, the member is directed to contact the requesting provider for alternative care/direction.

Policy 52: Post Services Appeal Process

A Post Services Appeal is a written grievance to North East Medical Services Management Services Organization (NEMS MSO) Utilization Management Department appealing the medical decision for a modified approval and/or denial of a requested service and/or treatment; or seeking resolution of a medical determination.

For health plans that do not delegate appeals authority, NEMS MSO coordinates with the health plan as follows:

- If an appeal is received in writing from a member or provider, NEMS MSO will immediately submit the appeal and pertinent documentation to the health plan's appeals department. NEMS MSO will cooperate to the fullest extent to gather and provide needed information to the health plan upon request.
- If NEMS MSO is notified by the health plan about a member or provider appeal filed directly to the health plan, NEMS MSO will provide the pertinent documentation within 10 business days to the health plan
- Pertinent documentation provided to the health plan should include the following:
  - A copy of the member's denial letter
  - A copy of the provider notification that identifies the physician who made the decision and his/her phone number
  - All clinical information that was reviewed by the medical group
  - A copy of the guideline referenced as the reason for the denial
  - Any alternative options provided to the member or provider, if separate from the member letter or provider notification
- NEMS MSO will receive from the health plan the decision to uphold or overturn the denial.
- If NEMS MSO's denial is upheld by the health plan, a copy of the member's resolution letter received from the health plan will be filed in the member's file.
- If NEMS MSO's denial is overturned by the health plan, the NEMS MSO Medical Director will review the decision. If the NEMS MSO Medical Director concurs with the health plan's decision, NEMS MSO will implement the health plan's appeal decision.
- If the NEMS MSO Medical Director does not concur with the health plan's decision to overturn the denial, the NEMS MSO Medical Director will discuss with the health plan's Medical Director about the decision. If the NEMS MSO Medical Director and health plan's Medical Director come to a mutual decision, NEMS MSO will implement the decision. If the NEMS MSO Medical Director and health plan's Medical Director cannot come to a mutual decision, NEMS MSO or the health plan may submit the case to an Independent Medical Review (IMR). The IMR process will provide an impartial review of medical decisions. NEMS MSO will implement the decision made by the IMR.

For health plans that NEMS MSO has delegated appeals authority, NEMS MSO will review and process the grievance as follows:

First Level Appeal
If a member, provider, or member representative does not agree with a decision regarding authorization approval and/or denial, the member or provider may initiate a written appeal (first-level appeal) to the following address:

North East Medical Services
Attn: MSO Post Services Appeal
2171 Junipero Serra Blvd., #600
Daly City, CA 94014
415-391-9686

The member, provider, or member representative must submit a Services Appeal Request (SAR) form in writing along with any relevant and supporting documentation within 180 days from the date of the Notice of Action (NOA).

The SAR must include:

- Patient's Name and DOB
- Patient's Contact Information (Address and Phone Number)
- Provider's Name and Contact Information (Address and Phone Number)
- Identification of the disputed service(s)
- Explanation of the basis that the provider and/or member believe the service(s) requested is medically necessary.
- Presentation of any additional relevant information that was not previously submitted for consideration in the original decision.

NEMS MSO will acknowledge the receipt of the appeal within five (5) working days of receipt of the SAR.

The First Level Appeal will be processed as follows:

- The NEMS MSO Medical Director (Reviewer or party not involved in the original determination) will review the SAR; the previous decision is reconsidered.
- The Reviewer, who was not involved in the initial determination, is responsible to seek advice from a provider in the same or similar specialty as the case in question if he/she has any reservations or unanswered questions regarding the case.

- The initial medical determination is reconsidered.

- The Reviewer will include a full investigation of the substance of the appeal, and any aspects of the clinical care involved in the case in question.

- A new determination is made as reversal or upheld of the denial status of the requested service(s) or treatment(s).

- If the appeal is for an acute or urgent condition, the Reviewer follows the "Expedited Appeals" Policy & Procedure.

NEMS MSO will issue a written determination regarding the Reviewer's decision, including a statement of the pertinent fact and reasons, to the provider, the member and the member's health plan within thirty (30) working days after receipt of the SAR.

If the Reviewer cannot make a decision within 30 working days due to special circumstances, a written notice providing reasons for the delay will be sent to the provider and member before the 30th working day.

If the new determination is a modification or reversal of the original decision, the NEMS UM Department will notify the provider and/or member within one business day followed by the written determination.

Second Level Appeal

If a member, provider, or member representative does not agree with the results of the review, the member or provider may submit an appeal in writing (Second Level Appeal) within 15 working days from the date of the reviewer's determination.

- The Second Level Appeal will be presented to the Utilization Management/Quality Improvement (UM/QI) Committee (a committee composed of board-certified practicing physicians) for review. Providers who were involved in the original and/or first level appeal determination should not be participating in the UMC review.

- The UM/QI Committee is responsible for seeking advice from a board-certified specialist practicing in the field of medicine relevant to the case, or in a similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment.

- The previous decision is reconsidered.

- The UM/QI Committee will include a full investigation of the substance of the appeal, and any aspects of the clinical care involved in the case in question.

- A new determination is made as reversal or upheld of the denial status of the requested service(s) or treatment(s).

NEMS MSO will issue a written determination regarding the UM/QI Committee's decision, including a statement of the pertinent facts and reasons, to the provider, the member, and the member's health plan within thirty (30) working days after receipt of the Second Level Appeal.

If the new determination is a modification or reversal of the original decision, the NEMS UM Department will notify the provider and/or member within one business day followed by the written determination.

Independent Medical Review (IMR)

If a member, provider, or member representative does not agree with the UM/QI Committee's decision, or if the disputed decision is upheld or the grievance is not resolved in thirty (30)

days, the member or provider has six (6) months to file for an Independent Medical Review directly to the Department of Managed Health Care.

The IMR option is also available if the member has completed two levels of internal reviews and its decision is unfavorable to the member, or the member has elected to bypass one or both levels of internal reviews and proceeded to independent reviewer, or NEMS MSO has exceeded its time limit for internal review(s), without cause and/or reaching a decision.

Decision Letter Content

All appeal decision letters must contain the following information, as applicable:

- A statement of the reviewer's understanding of the pertinent facts of the member's appeal
- The titles and qualifications, including title of the individuals participating in the review of the appeal
- A clear explanation for the decision, with the contractual or clinical rationale
- A reference to the evidence or documentation used as the basis for the decision (a copy of the appropriate guidelines regarding the issue)
- In the situation of a denial of or upheld the original decision, instructions for requesting a written statement of the clinical rationale and copies of the criteria used to make the decision (if these were not attached to the letter), when applicable
- Instructions for how to obtain copies of any or all of the documents relevant to the appeal(s) upon the member's request.
- A detailed description of the appropriate appeal rights, including the right to request an IMR through the appropriate regulator such as the Department of Managed Health Care or the Department of Insurance
- The original signature of the appeal reviewer, the reviewer's full name and phone number where he/she can be reached.

Supplementary Procedure

1) Emergent cases are processed expediently, and the clinical urgency of the situation is always accommodated. The Medical Director or a physician designee in the same or similar specialty as the case in question is involved in the medical determination, as necessary.
2) Situations that involve issues of quality are referred to the UM/QI Committee and/or the health plan for review and follow-up action(s).
3) All denials for investigational and/or experimental treatment for terminal illness will be issued directly by the health plan according to statutory law.
4) California Health and Safety Code 1374.30-1374.36 and AB1455 prohibit NEMS MSO UM or Claims Department to rescind or modify an authorization for health care services after the provider renders the service in good faith and pursuant to the authorization.
5) All Post Services Appeals must be routed to the UM Department for review and to maintain a log of correspondence.
6) All appeal cases are maintained confidentially in the NEMS MSO UM Department.

NORTH EAST MEDICAL SERVICES MSO
SERVICES APPEAL REQUEST

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Name of Parent or Guardian if Filing for Minor Child _____

Date of Birth _____ Health Plan ID _____

Street Address _____

City _____ State _____ Zip Code _____

Day Phone # _____ Evening Phone # _____

PROVIDER INFORMATION

Provider Name _____ Specialty _____

Provider Contact Address _____

Provider Contact Phone # _____

YOUR HEALTH PROBLEM

What is your health condition or doctor's diagnosis?

_____

Services / treatment that was denied and is on request for reconsideration:

_____

Do you have a condition that is a serious threat to your health? ⌗ Yes ⌗ No

If "yes", please explain: _____

_____

I am requesting for a review of my health condition and reconsideration of the services and/or treatment that was denied dated _____. I allow my providers, past and present, to release my medical records and any other information related to my case for this appeal.

Patient or Parent Signature _____ Date _____

Policy 53: Post-Stabilization Care

Post-stabilization services are medically necessary services, related to an emergency medical condition, provided after the member's condition is sufficiently stabilized, in order to maintain, improve or resolve the member's condition, so that the member can be safely discharged or transferred.

POLICY

In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies:

- NEMS MSO authorizes continued care for members who have received emergency services and care is stabilized, but the treating provider believes that the member may not be discharged safely.
- If NEMS MSO fails to authorize or deny a provider's request to provide necessary post-stabilization medical care within 30 minutes of the request, the necessary post-stabilization care shall be deemed authorized.

PROCEDURE

1. NEMS Clinic has 24-hour access for members and providers to discuss medical care for members who have received emergency services and care is stabilized, but the treating practitioner believes that the member may not be discharged safely. An on-call physician is available for consultation for post-stabilization care.

2. The NEMS on-call physician will review requests for necessary post-stabilization medical care within 30 minutes of receiving the call.

3. The NEMS on-call physician authorizes continued care for members who have received emergency services and care is stabilized, but the treating provider believes that the member may not be discharged safely.

4. If the on-call NEMS physician fails to authorize or deny a provider's request to provide necessary post-stabilization medical care within 30 minutes of the request, the necessary post-stabilization care shall be deemed authorized.

Policy 54: Provision of Blood Lead Screening

POLICY STATEMENT

1. North East Medical Services (NEMS) medical group benefits include blood lead level (BLL) screening for members who meet any of the following criteria:
    - At 12 and 24 months of age, or
    - When the health provider becomes aware during the periodic health assessment that a child within the age range of 12 to 24 months has no documented evidence that screening has been performed, or
    - When the health care provider becomes aware during the periodic health assessment that a child 24 to 72 months of age has no documented evidence of BLL test results when the child was 24 months or thereafter, or
    - When the health care provider becomes aware during the periodic health assessment that a child between 12 to 72 months of age has a circumstance that places the child at an increased risk of lead poisoning.

2. NEMS MSO informs medical groups, members, and primary care physicians that blood lead level screening of young children is required for all members up to the age of 72 months by including this policy in the Network Operations Manual and Pediatric Preventive Health Care Guidelines.

PROCEDURE

1. NEMS MSO informs medical groups and primary care providers (PCPs) that blood lead level (BLL) screening is required for children less than 72 months of age.

2. NEMS MSO informs its providers to document any attempts to provide BLL screening in the child's medical record, including any refusal by the member, parent, or guardian. If the BLL screening is refused, providers are instructed to have proof of voluntary refusal of the screening in the form of a signed statement from the parent or guardian, which is to be filed in the child's medical record. If the responsible party refuses to sign this statement, the refusal shall be noted in the member's medical record.

3. Providers must follow the latest guidelines from, including reporting results to, the California Department of Public Health's Childhood Lead Poisoning Prevention Branch (https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/CLPPBhome.aspx) . NEMS MSO informs all medical groups and PCPs of this requirement by including this policy in the Network Operations Manual, Pediatric Preventive Health Care Guidelines, and provider newsletter.

4. NEMS MSO informs its members of the availability and the importance of BLL screening through the member newsletter.

5. NEMS MSO assures that BLL screening is appropriately provided by physicians and medical groups when conducting a Facility Site Review and a Medical Record Review.

Policy 55: Public Health Emergency

According to the World Health Organization, a public health emergency (PHE) is defined as "an occurrence or imminent threat of an illness or health condition, caused by bio terrorism, epidemic or pandemic disease or (a) novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human facilities or incidents or permanent or long-term disability." NEMS MSO follows federal and state guidelines when there is a PHE declaration.

Coronavirus Disease 2019 Public Health Emergency

The Coronavirus Disease 2019, also known as COVID-19, was declared a PHE in the United States in January 2020. NEMS MSO follows federal and state guidelines as they are released and updated to provide healthcare services and support to our members.

NEMS MSO covers COVID-19 diagnostic testing, regardless of whether enrollees access such tests through in- or out-of-network providers. NEMS MSO does not require any type of prior authorization for
testing and does not impose medical management/utilization management criteria on testing.

NEMS MSO follows guidance from the Department of Managed Health Care (DMHC) on COVID-19 diagnostic testing:

- All members, including asymptomatic members with no known or suspected recent exposure to COVID-19, can get tested without prior authorization, utilization management, or cost-sharing.
- NEMS MSO must cover the member's COVID-19 testing regardless of whether the member receives the test from an in-network or out-of-network provider.
- There is no limit regarding the number of times a member may seek COVID-19 testing.
- If a member self-refers for a COVID-19 diagnostic test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers a member for a COVID-19 diagnostic test, NEMS MSO will cover the test without cost-sharing, prior authorization, or other medical management requirements

References: DMHC All Plan Letter 21-011 and 21-016

Policy 56: Public Health Programs

The Public Health Department has many programs for the public. The primary care physician (PCP) can refer members to the available programs directly. NEMS MSO case manager are knowledgeable about the available programs and can be a good resource for the providers. PCPs are encouraged to contact a NEMS MSO case manager for public health programs availability. Examples of the programs are:

1. Confidential HIV Testing is available through plan providers and confidential and anonymous testing is also available at Department of Public Health sites. NEMS MSO encourages members to seek these services from their PCPs or to provide the information to their PCP to ensure continuity and quality of care.

According to California law, providers must report new HIV cases within one working day by telephone in San Francisco to the HIV reporting line (618) 217-6335 or in Santa Clara County to the HIV Surveillance teams confidential lines at (408) 792-3727 or (408) 792-3733.

According to California law, providers must report AIDS cases within one week. Call the AIDS Office of the San Francisco Department of Public Health (SFDPH)at (415) 554-9000 or Santa Clara County's HIV Surveillance teams confidential lines at (408) 792-3727 or (408) 792-3733.

2. Preventive health services, Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are provided by the Department of Public Health.

3. Child Health and Disability Prevention Services (CHDP):
For those members in the CHDP program requiring follow-up for more serious medical problems (based on the PCP's medical judgment), a NEMS MSO case manager will assist the PCP in attempting to contact the member or his/her parent/guardian (i.e., at least two telephone contact attempts at different times of the day, and written notification).

Once NEMS MSO's follow-up attempts have failed, the NEMS MSO case manager will notify the health plan's case managers of the members requiring follow-up and the reason for concern. Members who are high priority for follow-up, based on severity of condition, will be referred to the district Public Health Nurse for an attempt at direct contact. Referrals for direct contact may be made by the PCP or health plan to the local CHDP program.

4. Immunizations:
While PCPs are responsible for providing immunizations according to the Advisory Committee on Immunization Practices (ACIP) recommended schedule, members may also self-refer to their local Department of Public Health (DPH) immunization clinics (various sites throughout San Francisco), which provide drop-in services and are open 9 a.m. to 5 p.m., Monday to Friday.
Members who live in Santa Clara County may contact the County of Santa Clara Public Health Department Immunization Program at (408) 792-5007.

DPH is to refer members back to their PCP in the following cases:

- A child less than six (6) months behind in all doses of vaccines according to the ACIP immunization schedule
- A non Medi-Cal adult requesting vaccination(s) prior to travel

DPH can provide immunizations to members on an "urgent need" basis defined as:

- A child who is six months or more behind on any dose of vaccine according to the ACIP immunization schedule
- A child aged 4.5 years or more with no prior immunizations or incomplete immunizations who presents between July 1 and the starting date of his/her school and is unable to obtain an appointment with his/her PCP prior to the school start date

PCPs are encouraged to enroll in the California Vaccines for Children (VFC) Program telephone: 1-877-243-8832 which reimburses vaccine costs for immunizations provided to Medi-Cal children. This program will pay for vaccines, while NEMS MSO reimburses the administration fee.

5. Tuberculosis:

In order to ensure the appropriate treatment of members with tuberculosis and coordination of care with the local DPH, NEMS MSO will refer eligible members for direct observed therapy (DOT) services. The DOT program provides, delivers, and oversees the outpatient treatment of select patients with active tuberculosis (TB).

PCPs refer members who meet the above criteria to the local DPH TB Control Program for evaluation for DOT services and document the referral in the member's medical record. If a member is accepted to the DOT program, the PCP will:

- Forward medical records, consult reports, laboratory reports and any additional information requested by the DPH.

- Coordinate appropriate treatment plan with the DPH and ensure continuity of care through on-going communication with the DPH TB Control Unit.

DPH provides families with information on local programs and resources at 1-800-300-9950 in San Francisco and 1-800-310-2332 in Santa Clara County.

Policy 57: Referral Cancellation

Providers and members may request a cancellation of the referral request at any time prior to the service rendered. The UM staff processes the request timely and appropriately.

POLICY

1. UM staff do not solicit any cancellation.
2. When UM receives a request for cancellation of a Treatment Authorization Request (TAR), the UM staff obtains appropriate information about the request.
3. Cancellation will be processed in a timely manner.
4. The cancellation of the request must not interrupt, withhold, or delay patient care or result in underutilization.

PROCEDURE

1. UM staff do not solicit any referral cancellations. Cancellation requests should come from the following sources:
    - Members
    - Requesting providers
    - Treating providers
    - Primary Care Providers (PCP)
2. The UM staff may receive a referral cancellation request prior to or after the authorization of the service. Once the service is rendered, the UM staff will not be able to process the cancellation request.
3. UM staff obtains appropriate information about the cancellation request:
    - Person requesting the cancellation
    - Reason for cancellation
    - Alternative plan of care for the member as needed
3. Cancellation requests will be processed in a timely manner. NEMS UM staff process the request as quickly as possible but no later than the turnaround time of 5 business days for routine and 72 hours for an urgent request.
4. The cancellation of the request must not interrupt, withhold, or delay patient care or result in underutilization. The UMC should assess if an alternative plan of care for the member is needed and in place. The UMC may refer the case to the NEMS case management team to coordinate care for the member to ensure needed services are provided.
5. The UMC may refer the case to the NEMS physician reviewer for consultation if there is a potential interruption, withhold or delay in patient care or if it results in underutilization. The physician reviewer may discuss the case with the requesting provider and PCP.

Policy 58: Second Opinion

Second Opinion

NEMS MSO members may request a second opinion from any qualified primary care provider (PCP) or specialist within the NEMS medical group. If a qualified specialist is not available within the NEMS medical group, a referral is provided within the health plan's network. If a qualified specialist is not available in the health plan's network, NEMS MSO will identify an out-of-network specialist. The second opinion from a qualified health professional will be provided at no cost to the member.

A) NEMS MSO provides a second opinion from a qualified health care professional when a member or provider requests it for reasons that include, but are not limited to, the following:
    1) The member questions the reasonableness or necessity of recommended surgical procedures.
    2) The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
    3) The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
    4) The treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plans of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
    5) The member has attempted to follow the provider's advice or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

B) A second medical opinion will be provided at no cost to the member, upon request by a member or participating health professional treating a member.
    1) The second medical opinion will be rendered by a PCP or Specialist (SCP) acting within the scope of practice and who possesses clinical background including training and expertise related to the particular illness or condition.
    2) If the member requests a second opinion about care from a PCP, the second medical opinion shall be obtained within the NEMS MSO network.
    3) If the member requests a second opinion about care from a SCP, the second medical opinion shall be given by a provider of the same specialty. This specialist shall be within the NEMS MSO network and may be selected by the member.
    4) If there is no participating provider within the NEMS MSO network or if the member requests a second medical opinion outside of the NEMS MSO network, NEMS MSO shall authorize a second opinion by a qualified provider outside of the network. NEMS MSO shall incur the cost or negotiate the fee arrangement of the second opinion by a qualified provider outside of the network.
    5) The authorization process takes into account the member's ability to travel to the provider rendering the second medical opinion.
    6) Any authorization or denial decision shall be provided in an expeditious manner.
    7) A written notification is sent to the provider and the member for any denial determination in compliance with notification timeframes.

8) The provider rendering the second opinion will provide the member & requesting provider with a consultation report including any recommended procedures or tests.

C) Member rights related to second opinions include:
- To be provided with the names of two physicians who are qualified to give a second opinion
- To obtain a second opinion within 30 calendar days, or if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member's condition and that does not exceed 72 hours
- To see the second opinion report

D) On a quarterly basis, the MSO Clinical Operation Manager reviews the second opinion log and randomly selects five files for review to ensure that second opinion files are processed correctly. The following items are reviewed for compliance:
- Request is appropriately approved or denied
- Second opinion is authorized or denied timely
- Second opinion is provided in-network if available or out-of-network if in-network is not available
- A provider in the same specialty is utilized for the second opinion
- If denied, the denial letter is sent to the member and provider in a timely manner

Policy 59: Sensitive Services

Sensitive services mean those services related to:

- Family planning
- Option Counseling/Pregnancy testing
- Abortion services
- Testing and treatment for sexually transmitted infections (STI)
- Confidential HIV testing and counseling
- Sexual assault
- Pregnancy and pregnancy related services
- Drug and alcohol abuse
- Outpatient mental health counseling and treatment

Minors and adult members have the right to timely access to confidential and sensitive services without pre-authorization. Minors and adolescents have the right to access sensitive services without parental consent.

Information and records related to sensitive services are strictly confidential and shall not be released to any third party without the consent of the member involved, including adolescents.

At the time a member receives sensitive services outside of NEMS MSO, the member must sign a form to either agree or refuse to release medical information in order for NEMS MSO to be billed for services.

Abortion Services

Medi-Cal members are encouraged to receive abortion services from a provider within NEMS MSO network. However, members may self-refer to any provider that is contracted with NEMS MSO, outside of NEMS MSO, or outside of the Health Plan's provider network for outpatient abortion services.

Members in the Healthy Kids program may self-refer to any provider that is contracted with NEMS MSO for outpatient abortion services.

Outpatient abortion services are not subject to prior authorization, medical justification or any other utilization management procedures if provided in the United States. NEMS MSO requires prior authorization for provider requests for inpatient hospitalization for the performance of an abortion.

NEMS MSO members must obtain prior authorization for the use of general anesthesia, regardless of whether the abortion is performed in an office, outpatient facility or a hospital.

If NEMS MSO does not have a provider of abortion services, NEMS MSO arranges for services and pays all professional fees and facility fees. NEMS MSO will assist any provider or member to access abortion services.

Family Planning

See Policy on Family Planning Services

Direct Access to OB/GYN Services

A NEMS MSO member may self-refer to any NEMS MSO network obstetrician/gynecologist or family practice physician for gynecological and obstetric services. A NEMS MSO member shall not be required to obtain prior approval from another provider, health plan, or medical group prior to making an appointment and obtaining direct access to an obstetric and gynecological or family practice physician for obstetric or gynecological services.

Adult Sterilization and Consent

See Policy on Sterilization Consent (PM330)

Sexually Transmitted Infections (STI)

Medi-Cal members can access services for STIs from *any* willing provider, both in network and out-of-network. NEMS MSO will cooperate with the local health departments to promote the diagnosis and treatment of members with STIs. Care provided for STIs includes testing, diagnosis, immediate treatment and medications. The local health department and NEMS MSO will collaborate to ensure members receive immediate care when the member presents with an STI. The local health department and other out-of-plan providers are to refer the member back to the Primary Care Physician (PCP) for any conditions requiring ongoing care beyond the initial diagnosis and treatment of the STI. For Plan coverage of these services, members may sign a refusal of medical record release in lieu of releasing their medical records.

Confidential HIV and STI Testing

Medi-Cal members are encouraged to receive sensitive services from a provider within the NEMS MSO network. However, members may self-refer to any provider that is contracted with NEMS MSO network, outside of NEMS MSO network, or outside of the health plan's provider network for outpatient sensitive services.

Members in the Healthy Kids programs may self-refer to any provider that is contracted with NEMS MSO for outpatient sensitive services. All sensitive services are confidential and include:

- HIV testing, education, counseling, and follow-up services
- Sexually Transmitted infection (STI) screening, diagnosis, treatment and counseling and follow-up services

Infants, children, and adolescents under the age of 21, who are confirmed HIV positive, may be eligible for California Children's Services (CCS).

Anyone 12 years of age or older may obtain STI and HIV services without parental consent or disclosure.

Payment to Non-Medical Group Providers

Based on the definition of the family planning services listed above, NEMS MSO is required to reimburse non-NEMS providers for those services at Medi-Cal rates.

Policy 60: Sentinel Events

OBJECTIVE(S): To have a positive impact in improving patient care, treatment, and services and preventing sentinel events.

REFERENCES: 2004 JCAHO Comprehensive Accreditation Manual for Ambulatory Care (CAMAC), Standards PI.2.20, PI.2.30, PI.3.10, PI.3.20.

POLICY:

Sentinel events reporting is part of NEMS MSO's risk management program. Risk management is important to NEMS MSO because it reinforces our commitment to provide quality care to every patient. Risk management is an organized and regular activity to control and decrease situations that may result in less than optimum quality of care or potential loss to the organization. Sentinel events reporting establishes communication, ownership and involvement, which are keys to providing quality care and maintaining an effective risk management program.

In this Policy:

I. Sentinel events are defined
II. Procedure to report sentinel events is outlined
III. Sentinel events are investigated timely using root cause analysis
IV. Improvements are implemented to reduce risk
V. Effectiveness of the improvements are monitored
VI. Appendices and Other Materials

I. DEFINITIONS:

Sentinel Event: An unexpected occurrence involving death or serious physical and/or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Sentinel events are "sentinel" because they signal the need for immediate investigation and response.

Near Miss: Used to describe any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. Such a "near miss" falls within the scope of the definition of a sentinel event but outside the scope of those sentinel events that are subject to review.

II. REPORTING PROCEDURES:

NEMS employees are required to submit incident reports to NEMS Administration (see Policy and Procedure for Incident Reports). Incidents which fall into the definition of a sentinel event will require a special response.

Suspected Sentinel Events

1. If a staff member witnesses, discovers or has direct knowledge of a sentinel event or a potential risk of a sentinel event, the staff member should provide emergency care as appropriate.
2. The staff member must report the sentinel event or the potential risk of a sentinel event to his or her department supervisor immediately.
3. The staff member should complete an Incident Report Form and return it to the supervisor within 3 working days *(See Incident Report Policy*). The report should be immediately forwarded to the Medical Director(s) or CEO.
4. Routine Incident reports will also be reviewed on a regular basis by the Medical Director(s) and NEMS Administration.
5. The Medical Director(s) and CEO will determine as to whether the incident qualifies as a Sentinel Event or not. If necessary, further investigation concerning the course of events should be conducted. If the incident is deemed a Sentinel Event, it should be classified as "Reviewable" or "Not-Reviewable" by JCAHO standards.

The review process should be:

- Accomplished by the Analysis Team
- Evaluating factual information
- Completed in a timely fashion
- Routed to specific departments, if necessary
- Analyzed to facilitate corrective action
- Maintained in the strictest of confidence
- Logged into a reference log
- Systematically reviewed for trend analysis
- Readily retrievable

III. ROOT CAUSE ANALYSIS:

Once an incident is determined to be a Sentinel Event, a Root Cause Analysis must be done within **45 calendar days** of the event or of becoming aware of the event.

> *Root Cause Analysis (see appendix): is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. It identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future.*

The Analysis Team (consisting of at least the Medical Director(s) and Administration) will investigate, review, and evaluate the incident promptly by analyzing root cause, which focuses primarily on systems and processes, not individual performance.

IV. ACTION PLAN:

The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future.

The plan should address responsibility for implementation. oversight, pilot testing as appropriate, timelines, and strategies for measuring the effectiveness of the actions.

The action plan is designed to implement improvements to reduce risk of future adverse incidents and monitor the effectiveness of those improvements. The Medical Director may present the sentinel event to the Quality Assurance Committee for review and recommendations. The corrective action plan may include:

- Patient and staff education
- Change of policies and procedures
- Person responsible for implementation and oversight
- Timelines to complete the corrections
- Strategies for measuring the effectiveness of the actions

An action plan should:

- Identify changes that can be implemented to reduce risk or formulate a rationale for not undertaking such changes
- Identify, in situations where improvement actions are planned, who is responsible for implementation, when the action will be implemented (including pilot testing), and how the effectiveness of the actions will be evaluated

V. MONITORING:

The Medical Director or the Quality Assurance Manager continuously monitors and presents to the Quality Assurance Committee the effectiveness of the corrective actions. Further adjustment of the corrective action plan may be required.

VI. APPENDICES:

Please see *Reviewable and Non-Reviewable Sentinel Events* and *Root Cause Analysis* documents.

Appendix Table 1: Reviewable and Non-Reviewable Sentinel Events

The Joint Commission distinguishes between reviewable and non-reviewable sentinel events. Reviewable events have more serious implications. Reviewable events have the following characteristics:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

or

- The sentinel event is one of the following:
  - Suicide of a patient in a setting where the patient receives around-the-clock care, treatment, and services (for example, hospital, residential treatment center, crisis stabilization center)
  - Unanticipated death of a full-term infant
  - Infant abduction or discharge to the wrong family
  - Rape

  Rape, as a reviewable sentinel event, is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the health care organization, including oral, vaginal, or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ, or object. One or more of the following must be present to determine reviewability:

    - Any staff-witnessed sexual contact as described above
    - Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact
    - Admission by the perpetrator that sexual contact, as described above, occurred on the premises
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
  - Surgery on the wrong patient or wrong body part.
    - All events of surgery on the wrong patient or wrong body part are reviewable under the policy, regardless of the magnitude of the procedure or the outcome.

Non-reviewable sentinel events are those which do not have the above characteristics. Examples of more reviewable sentinel events and nonreviewable events are provided in Appendix Table 1

EXAMPLES OF REVIEWABLE SENTINEL EVENTS AND NONREVIEWABLE EVENTS

Sentinel Events That are Reviewable Under the JCAHO's Sentinel Event Policy **

1. Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error.
2. Any suicide of a patient in a setting where the patient is housed around-the-clock, including suicides following elopement from such a setting.
3. Any elopement, that is an unauthorized departure, of a patient from an around-the-clock care setting resulting in a temporally related death (suicide or homicide) or major permanent loss of function.
4. Any procedure on the wrong patient, wrong side of the body, or wrong organ. Any intrapartum (related to the birth process) maternal death.
5. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.
6. Assault, homicide, or other crime resulting in patient death or major permanent loss of function. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.
7. Hemolytic transfusion reaction involving major blood group incompatibilities.

Note: An adverse outcome that is *directly related to* the natural course of the patient's illness or underlying condition, for example, terminal illness present at the time of presentation, is not reportable except for suicide in, or following elopement from, a 24-hour care setting *(see* above).

Sentinel Events That are Non-reviewable Under the JCAHO's Sentinel Event Policy

1. Any “near miss.”
2. Full return of limb or bodily function to the same level as prior to the adverse event by discharge or within two weeks of the initial loss of said function.
3. Any sentinel event that has not affected a recipient of care (patient, client, resident). Medication errors that do not result in death or major permanent loss of function.
4. Suicide other than in an around-the-clock care setting or following elopement from such a setting.
5. A death or loss of function following a discharge "against medical advice (AMA)."
6. Unsuccessful suicide attempts.
7. Unintentionally retained foreign body without major permanent loss of function.
8. Minor degrees of hemolysis with no clinical sequelae.

Note: In the context of its performance improvement activities, an organization may choose to conduct intensive assessment, for example, root cause analysis, for some nonreportable events. Please refer to the "Improving Organization Performance" chapter of this Joint Commission accreditation manual.

** This list may not apply to all settings. ** These events MUST BE sent to the JCAHO for review.*

Root Cause Analysis

Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. It identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future.

1. Special Cause is a factor that intermittently and unpredictably induces variation over and above what is inherent in the system. It often appears as an extreme point (such as a point beyond the control limits on a control chart) or some specific, identifiable pattern in data
2. Common Cause is a factor that results from variation inherent in the process or system. The risk of a common cause can be reduced by redesigning the process or system.

Once an incident is determined to be a Sentinel Event, a thorough and credible root cause analysis must be done by the NEMS Medical Director(s) and CEO within **45 calendar days** of the event or of becoming aware of the event.

A root cause analysis focuses primarily on systems and processes, not individual performance. The Medical Director and the Chief Operating Officer should evaluate the following areas that may have caused the event:

- Behavioral assessment process
- Physical assessment process
- Patient identification process
- Patient observation procedures
- Care planning process
- Staffing levels
- Orientation and training of staff
- Competency assessment/ credentialing
- Supervision of staff
- Communication with patient/ family
- Communication among staff members
- Availability of information
- Adequacy of technological support
- Equipment maintenance/ management
- Physical environment
- Security systems and processes
- Control of medications: storage/ access
- Labeling of medications

Investigation of a sentinel event is a priority assignment. At the minimum, the following will be accomplished:

- Interview any involved persons
- Audit the medical record for content
- Securing of any named equipment
- Evaluation of the environmental site
- Inspection of the physical plant
- Obtaining photographs, if indicated
- Collecting a copy of the policy or procedure
- Third party administration contact

Each identified root cause will be evaluated, and the following determinations shall be made based on the available information:

- Whether each of the specific root causes can be resolved,
- An explanation of the corrective action plan or rationale for its exclusion, as well as
- An identification of measurable indicators of success and the regularity of the review.

A root cause analysis will be considered *acceptable* if it has the following characteristics:

- The analysis focuses primarily on systems and processes, not on individual performance
- The analysis progresses from special causes in clinical processes to common causes in organizational processes
- The analysis repeatedly digs deeper by asking "Why?"; then when answered, "Why?" again; and so on
- The analysis identifies changes that could be made in systems and processes (either through redesign or development of new systems or processes) which would reduce the risk of such events occurring in the future
- The analysis is thorough and credible

To be *thorough,* the root cause analysis must include the following:

- A determination of the human and other factors most directly associated with the sentinel event and the process(es) and systems related to its occurrence
- An analysis of the underlying systems and processes through a series of "Why?" questions to determine where redesign might reduce risk
- An inquiry into all areas appropriate to the specific type of event as described in Table 2, "Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events"
- An identification of risk points and their potential contributions to this type of event
- A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist

To be *credible,* the root cause analysis must do the following:

- Include participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review
- Be internally consistent (that is, not contradict itself or leave obvious questions unanswered)
- Provide an explanation for all findings of "not applicable" or "no problem".
- Include consideration of any relevant literature

Joint Commission Reporting

If the Joint Commission becomes aware (either through voluntary self-reporting or otherwise) of a sentinel event that meets the criteria of a reviewable event, and the event has occurred at NEMS, then NEMS MSO shall do the following:

Submit to the Joint Commission its root cause analysis and action plan. or otherwise provide for Joint Commission evaluation of its response to the sentinel event under an approved protocol, within 45 calendar days of the known occurrence of the event.

Policy 61: Sexually Transmitted Infections

POLICY

1. The North East Medical Services (NEMS) Medical Group shall provide members with prompt and confidential access to in-plan and out-of-plan providers for sexually transmitted diseases (STD) or sexually transmitted infections (STI) services, including Chlamydia screening services.
2. For the treatment of sexually transmitted diseases or infections, Medi-Cal members may see any provider who accepts Medi-Cal without referral or authorization.
3. Under California law, minors ages 12 to 18 years old can receive medical care for the diagnosis and treatment of STD/STI without parental consent.
4. NEMS MSO educates its members and providers about the importance of screening services for STD's and STI's.

PROCEDURE

1. NEMS MSO informs the medical group and primary care providers about STD/STI and Chlamydia screening requirements by including this policy in the Network Operations Manual and sharing the NEMS Pediatric and Adult Preventive Health Guidelines. Both of these documents include the below highlights:
    - Primary care providers (PCPs) are responsible for identifying members who may be at risk for Chlamydia infection through periodic health assessment and screening visits or at any other visit.
    - Sexually transmitted disease/sexually transmitted infection (STD/STI) can be presumptively diagnosed and treated without prior authorization.
    - STD/STI & Chlamydia screening is provided to:
        - Sexually active females (including pregnant women) 25 years of age and younger – Screen for Chlamydia annually and STD/STIs when symptomatic
        - Sexually active females (including pregnant women) over 25 years of age who are at increased risk of infection.
        - Men of any age who have sex with men – Screen for STD/STIs annually
        - Heterosexual males who are at increased risk of infection, symptomatic, or if a partner is diagnosed with an STD/STI
2. NEMS MSO informs PCPs that they must document the follow-up of positive Chlamydia and STD/STI results.
3. NEMS MSO informs PCPs that they must document any attempts and member refusals of Chlamydia and STD/STI screening.
4. NEMS MSO informs the PCPs to follow their current County Department of Public Health STD MOU guidelines and requirements including:
    - Reporting Chlamydia and STD/STIs and communicable diseases
    - Confidentiality
    - Consulting and/or collaboration with the County Department of Public Health STD staff on follow-up and treatment
5. NEMS MSO informs members of the availability of STD/STI and Chlamydia screening, including sexually active individuals 25 years of age and younger, through the member newsletter and Evidence of Coverage.

6. NEMS MSO monitors that STD/STI and Chlamydia screening is appropriately provided during Medical Record and Facility Site Reviews, and through monitoring population screening rates annually.
7. NEMS MSO takes corrective action to improve rates when problems are identified and opportunities for improvement exist.

Policy 62: Specialty Referral Tracking

POLICY

NEMS MSO has an established system to track and monitor referrals requiring prior authorization, including referrals to non-contracting providers. Specialty referrals that remain open or unattached to a claim after 120 days from date of approval are reported to the Health Plan and followed up with requesting providers.

PROCEDURE

A. Medical Tracking Clerks follow up with PCPs, members, and specialists about referrals using the Referral Orders Tracking Log which shows overdue referrals and how many days or months the referrals are overdue.

Referral Orders Tracking Log
All referral order data is tracked in the Referral Orders Tracking Log which contains the following information about each referral:

1. Status of referral
2. Ordering information (brief summary of referral to provider specialty, reason)
3. Patient MRN, Name, DOB
4. Order #
5. Order Date
6. Location (NEMS site where referral originated)
7. Referral Coordinator Comments
8. Comments (clinical)
9. Reason for referral
10. Time Frame
11. Due Date
12. Appt Date
13. Priority
14. PCP
15. Referring provider
16. Refer to Physician
17. Refer to Specialty
18. Scheduled Date
19. Scheduled Reason
20. Additional Info
21. # of Extensions
22. Overdue or Not

B. NEMS MSO tracks and monitors specialty referrals as required by the Health Plan.

1. NEMS MSO uses monthly and quarterly reports to monitor the following types of referrals:
    - Authorized
    - Denied

- Deferred
- Modified
- Unused

2. NEMS MSO UM Department performs routine internal audits on prior authorization turnaround time to monitor the timeliness of referrals.
3. Open/unused referrals are tracked and reviewed for potential underutilization and plans are implemented as needed to address utilization issues.
4. NEMS MSO follows up on unused referrals to ensure the member receives the approved service by sending notification to requesting providers that the member has an outstanding specialty referral that has not been used for longer than 120 days from date of approval.
5. Specialty referral monitoring reports are submitted to the Health Plan in accordance with the specified timeline.

C. NEMS MSO distributes referral policies to ensure all contracting health care providers are aware of the referral process and tracking procedures.

Policy 63: Standing Specialist Referrals Including HIV/AIDS

POLICY

NEMS MSO issues standing specialist referrals to reduce or eliminate the need for repeated primary care provider (PCP) authorization when regular use of specialty services is medically appropriate.

1. A member, who requires continuing specialized care over a prolonged period for a life-threatening, degenerative or disabling condition, including Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), may be allowed a standing referral to a specialist who has expertise in treating the condition or disease for the purpose of having the specialist coordinate the member's healthcare.
2. Referrals to the specialist or specialty care center should have sufficient expertise in treating the condition or disease. Only specialists within the area of expertise and training will be authorized to provide the health care services. For example, when authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialist knowledge of HIV medicine, NEMS MSO will refer the member to an HIV/AIDS specialist who meets the California Health and Safety Code criteria.
3. The PCP, specialist and designated physician determine that continuing care from a specialist is needed and referrals are made based on an agreed upon treatment plan, if any. Treatment plans may limit the number of specialist visits or the length of time the visits are authorized and may require the specialist to make regular reports to the PCP.
4. NEMS MSO appropriately approves the treatment plan or a current standing referral to a specialist or specialty care center when a member requires specialized medically necessary care over a long period of time.
5. After receiving standing referral approval, the specialist is authorized to provide healthcare services that are within the specialist's area of expertise and training to the member in the same manner as the PCP.
6. Decisions will be made within the time frames appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed 3 business days from the date that all necessary information is received.
7. If authorized, the actual referral will be made within 4 business days of the date the proposed treatment plan is approved by the MSO UM physician reviewer.
8. The PCP must refer to an out-of-network specialist, if one is not available within NEMS MSO, who can provide appropriate specialty care to the member. NEMS MSO authorizes an out-of-network specialist or specialty care center that have sufficient expertise in treating the condition when an in-network provider is not available.

NEMS MSO distributes referral policies to PCPs and has established a system to track and monitor specialty referrals requiring prior authorization.

PROCEDURE

A member can receive a standing referral (defined as two or more visits) to a specialist to maximize the member's access to a provider with demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring of the member's adherence to the regimen.

1. The PCP or NEMS member may request a standing referral by submitting a request to NEMS MSO Utilization Management Department.
2. The NEMS MSO physician reviewer determines the medical appropriateness of the standing referral request.
3. NEMS MSO may require a treatment plan when authorizing a standing referral. The treatment plan is made in consultation with the PCP, specialist and member, and may specify the frequency and intensity of specialist visits and authorize a course of treatment, including tests and procedures.
4. NEMS MSO makes a decision to approve or deny a request for a standing referral within three (3) business days of the date of the request and the receipt of all necessary records.
5. The actual referral will be made within four (4) business days of the date the proposed treatment plan is approved.

Specialist Referral Tracking System

NEMS MSO is responsible for establishing a system to track and monitor specialist referrals requiring prior authorization by NEMS MSO. Refer to the policy on "Specialty Referral Tracking" in this manual.

1. Specialist referrals that require prior authorization are referrals made to specialists outside of the NEMS Medical Group for services not available within the medical group.
2. Medical referral coordinators follow up with PCPs, members, and specialists about referrals.
3. NEMS MSO Utilization Management Department runs a quarterly report to monitor all specialist referrals to determine if a claim has been submitted for each referral.
4. Notification will be sent to each referring provider of authorized referrals that have not been matched to a claim.
5. The provider can then follow-up with the member receiving a referral to ensure that the member is seen by that specialist.

DEFINITIONS

1. A "Standing Referral" means a referral by a primary care provider to a specialist for more than one visit, as indicated in the treatment plan, if any, without the primary care provider having to provide a specific referral for each visit.

2. HIV/ AIDS Specialist means a provider credentialed by an accrediting organization such as the AAHIVM (American Academy of HIV Medicine) as an HIV specialist and who elects to be listed as an HIV specialist in the NEMS MSO Provider Directory.

Policy 64: Sterilization Consent (PM330)

POLICY

NEMS MSO ensures that the reproductive sterilization services provided to its male and female members meet all federal requirements. Medi-Cal members are subject to a 30-day waiting period. Additionally, consent is not only voluntary and fully informed, but the individual must also be allowed to make a free selection of the method for sterilization.

PROCEDURE

Prior to performing any sterilization procedures, practitioners must complete the PM 330 Consent for Sterilization Form, as required by law, and ensure all of the following:

- Correct PM 330 Consent Form
- Patient to be sterilized is at least 21 years of age at the time the consent for sterilization is obtained, is not mentally incompetent, is able to understand the content and nature of the informed consent process, and is not institutionalized and has signed and dated the consent form
- An interpreter is provided if there is evidence that the patient does not understand the language and/or text of the informed consent process
- Appropriate person completing consent section
- Physician completes section information as applicable and sign and date the PM 330 Consent Form
- Sterilization is performed at least 30 days, but not more than 180 days, after the date upon which informed consent was obtained for the sterilization, except in cases involving emergency abdominal surgery or premature delivery in which specific requirements are documented to have been met
- A copy of the DHCS Booklet on Sterilization is provided to the patient by either a physician or by the physician's designee, as part of the informed consent process for sterilization prior to the member signing the PM 330 Consent Form
- The physician or the physician's designee reviewing the informed consent with the member also provides the individual with a copy of the consent form
- Provision of DHCS Booklet on Sterilization is documented in the medical record

The physician must document the informed consent process in the medical record and include the signed PM 330 Consent Form in the medical record. Claims for sterilization must have a copy of the PM 330 Consent Form attached or payment will be denied.

Policy 65: Termination of a Provider or Hospital Contract (AB 1286)

POLICY STATEMENT

NEMS MSO will comply with the legislative mandate as follows when terminating a provider contract for all provider types (PCPs, specialists, ancillary, etc.).

Termination for Cause
(a) Immediate Termination. NEMS shall have the right to terminate a provider immediately in the event that the provider, in NEMS' sole discretion, violates or fails to comply with any of the requirements of the contract.

(b) Termination of Provider by Health Plan. In the event that a Health Plan contracting with NEMS notifies NEMS that the Health Plan wishes to remove a provider from the Health Plan's roster of Participating Providers, NEMS shall have the right to immediately terminate provider's participation in said Health Plan and from NEMS entirely. If such determination results in provider's termination from NEMS for a "medical disciplinary cause or reason" as defined in California Business and Professions Code Section 805, provider shall be entitled to a hearing in accordance with applicable state law.

(c) Unplanned Termination. In the event that the termination is due to unforeseen circumstances such as death of a provider or close of a provider business, NEMS MSO will work with PCP and specialists to ensure that the patient has a safe transition to other provider(s).

Termination without Cause
Provider may terminate the contract by giving of not less than ninety (90) days prior written notice to NEMS. NEMS may terminate a provider's contract by giving of not less than thirty (30) days prior written notice to the provider.

Continuous Coverage of Services by a Terminated Provider

NEMS MSO will notify health plan of a provider termination. If a member is receiving care for an acute condition, a serious chronic condition, a high-risk pregnancy, or any pregnancy that has reached its second trimester, NEMS MSO will review requests for transitional services.

If the terminating practitioner is unavailable, the Care Manager assists the member to transfer care to an appropriate in-network practitioner.

Coverage will be extended for a longer period if necessary for a safe transfer to another provider. This coverage is not provided if the provider in question left NEMS MSO voluntarily, does not agree to comply or does not comply with the same contractual terms in effect prior to terminations, or was terminated for a medical disciplinary cause, fraud, or other criminal activity.

PROCEDURES

1. NEMS MSO will provide written notification to members of a terminating provider at least 60 calendar days prior to the effective termination date.

2. NEMS MSO will review the following criteria to determine whether the treatment or care of current members can be transferred to another provider without compromising quality of care:
    - MCG Guidelines or other treatment guidelines
    - Community standards of practice
    - Treatment or care can be provided by a provider in matching specialty
    - Current treatment or care can be transitioned timely to another provider without any delay in treatment or care
    - Coordination of care can be resumed in a timely manner
    - Provider office is accessible to member
    - Access and availability of the matching provider or specialist
    - Linguistic match if possible, otherwise, interpreter service is provided

3. At the request of the member, NEMS MSO will provide continuity of care by a terminated provider seeing current members or by a non-participating provider seeing a new member. The completion of services shall be provided by a terminated provider who, at the time of the contract's termination, was providing services to a member for one of the following conditions:
    - An acute condition – Services provided for the duration of the acute condition.
    - A serious chronic condition – Services provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, not to exceed 12 months from the termination of the contract.
    - A pregnancy – Services provided for the duration of the pregnancy and immediate post-partum period.
    - A terminal illness – Services provided for the duration of the terminal illness.
    - A newborn child – Services provided for the care of a newborn child between birth and 36 months of age, not to exceed 12 months from the termination of the contract.
    - Surgery or other procedure authorized by NEMS MSO as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days from the contract termination date.

    Unless otherwise agreed to, services rendered after the contract termination shall be compensated at rates and methods of payment used by NEMS MSO for currently contracting providers providing similar services who are not capitated. Neither NEMS MSO nor the provider is required to continue the services if the provider does not accept these payment rates.

4. NEMS MSO will notify the Health Plan of provider terminations in a timely manner and choose another provider to assume the terminating providers' members. Members have the option of selecting another provider should they choose not to accept the new provider assigned.

Policy 66: Tobacco Cessation Program

Tobacco cessation interventions may prompt smokers to initiate a quit attempt, which may not have otherwise occurred without an intervention. Patients who stop smoking often experience various health benefits from quitting and as such, quitting can reduce health costs associated with tobacco-related illness and treatment.

POLICY

1. NEMS provider team encourages smokers to quit smoking
2. NEMS provider team assists members in quitting tobacco use
3. NEMS evaluates the effectiveness of the tobacco cessation program annually

PROCEDURE

1. NEMS provider team assesses patients over 18 years old of their smoking history and document in the Electronic Health Records. The provider team includes PCP, specialists, nursing staff, health educator, social worker, case managers, etc. Smoking cessation activities can be done via phone and/or in-person visits.

2. NEMS provider team should provide smoking cessation intervention for all patients who have a documented history of tobacco use. Activities may include the following:
   - Advise smokers to quit
   - Prescribe smoking cessation medications
   - Discuss cessation methods or strategies to quit
   - Provide education materials in member's language
   - Refer member to smoking cessation program in the community

3. NEMS Quality Improvement team evaluates the effectiveness of the NEMS tobacco cessation program quarterly. The rates of whether the provider team provided smoking cessation intervention to smokers is tracked by the Practice Improvement Program Committee. Benchmark is set every year. If benchmark is not met, interventions will be taken to improve the rate.

Policy 67: Transgender Services

PURPOSE

To clarify transgender services as a Medi-Cal covered benefit, ensuring access to covered services for transgender beneficiaries, and to outline the process of MSO Utilization Management (UM) reviewing and approving Treatment Authorization Requests (TAR) for gender affirmation services.

POLICY

NEMS MSO as the administrator handling medical management services for NEMS and Hospitals that contract with Managed Care Plans (MCP) as Risk Bearing Organization (RBO), must ensure delegated covered services are provided to all eligible members per DHCS and MCP guidelines, including transgender beneficiaries.

Nondiscrimination Laws
The Insurance Gender Nondiscrimination Act (IGNA) prohibits MCPs from discriminating against individuals based on gender, including gender identity or gender expression (Health and Safety Code Section (§)1365.5). The IGNA requires that MCPs (and subcontractors) provide transgender members with the same level of health care benefits that are available to non-transgender members.

In addition, the Affordable Care Act (ACA) and the implementing regulations prohibit discrimination against transgender members and require MCPs (and subcontractors) to treat members consistent with their gender identity (Title 42 United States Code § 18116; 45 Code of Federal Regulations (CFR) §§ 92.206, 92.207; see also 45 CFR § 156.125 (b)). Specifically, federal regulations prohibit MCPs (and subcontractors) from denying or limiting coverage of any health care services that are ordinarily or exclusively available to members of one gender, to a transgender member based on the fact that a member's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available (45 CFR §§ 92.206, 92.207(b)(3)). Federal regulations further prohibit MCPs (and subcontractors) from categorically excluding or limiting coverage for health care services related to gender transition (45 CFR §

NEMS MSO does not deny or limit coverage of any health care services that are ordinarily or exclusively available to beneficiaries of one gender, to a transgender beneficiary based on the fact that a member's gender assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such services are ordinarily or exclusively available.

Treatment for gender dysphoria is a covered Medi-Cal benefit when medically necessary. Medically necessary covered services are those services that "are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness or injury" (California Code of Regulations [CCR], Title 22, Section 51303). Medical necessity is assessed, and services shall be recommended by licensed mental health professionals, physicians, and surgeons experienced in treating patients with gender dysphoria.

MCPs are contractually obligated to provide medically necessary covered services to all members, including transgender members. State law defines "medically necessary" as follows:

(a) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

(b) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions.

MCPs must also provide reconstructive surgery to all members, including transgender members.
The analysis of whether or not a surgery is considered reconstructive surgery is separate and distinct from a medical necessity determination. State law defines reconstructive surgery as "surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease…to create a normal appearance to the extent possible." In the case of transgender members, gender dysphoria is treated as a "developmental abnormality" for purposes of the reconstructive statute and "normal" appearance is to be determined by referencing the gender with which the member identifies.

Analyzing Transgender Service Requests
MCPs must analyze transgender service requests under both the applicable medical necessity standard for services to treat gender dysphoria and under the statutory criteria for reconstructive surgery. A finding of either "*medically necessary to treat gender dysphoria*" or "*meets the statutory criteria of reconstructive surgery*" serves as a separate basis for approving the request.

If the MCP determines that the service is medically necessary to treat the member's gender dysphoria, the MCP must approve the requested service. If the MCP determines the service is not medically necessary to treat gender dysphoria (or if there is insufficient information to establish medical necessity), the MCP must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration the gender with which the member identifies.

Clinical guidance for the treatment of gender dysphoria is found in the most current "Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People," published by the World Professional Association for Transgender Health (WPATH) on the WPATH website (www.wpath.org).

1.
2.

Covered Medi-Cal benefits include:

- Mental and behavioral health (MBH) services
-

- Hormonal therapy
-
- A variety of surgical procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender
-

- **Criteria for Genital Surgery (two MBH referrals):**
  - Persistent, well-documented gender dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - At least 18 years of age
  - If significant medical or mental health concerns are present, they must be well controlled
  - 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual)
  - 12 continuous months of living in a gender role that is congruent with their gender identity (for Male to Female (MtF) patients)

Criteria for Breast/Chest Surgery (one MBH referral):
Criteria for mastectomy and creation of a male chest in Female to Male (FtM) patients:

- Persistent, well-documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- At least 18 years of age
- If significant medical or mental health concerns are present, they must be reasonably well controlled

Hormone therapy is not a prerequisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

- Persistent, well-documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- At least 18 years of age
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

  Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

- **Covered benefits** may include the following:
- **MtF Patients**
  - Clitoroplasty
  - Orchiectomy
  - Penectomy
  - Vaginoplasty
  - Augmentation mammoplasty (breast augmentation)
  - Facial hair reduction

FtM Patients

- Hysterectomy/salpingo-ophorectomy
- Metoidioplasty
- Phalloplasty
- Placement of testicular prostheses
- Scrotoplasty
- Urethroplasty
- Vaginectomy
- Labiaplasty
- Mastectomy

Other surgeries in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation.

- Reduction thyroid chondroplasty (reduction of the Adam's apple)
- Voice modification surgery
- Suction-assisted lipoplasty (contour modeling) of the waist
- Rhinoplasty (nose correction)
- Facial bone reduction
- Face-lift
- Blepharoplasty (rejuvenation of the eyelid)
- Liposuction, lipofilling, and pectoral implants

THIRD PARTY LIABILITY (TPL)

By Federal and State statues, the Medicaid program is the payer of last resort. If another insurer or program is known to exist, provider must bill the recipient's other health coverage before billing Medi-Cal for the covered services. This is known as the "third party liability" or TPL.

Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs (unless specifically excluded by Federal statute). Third party payers are not responsible for reimbursing Medicaid for any services that are not covered under the Medicaid State plan.

For many years, Medicare did not cover sex reassignment surgery for transgender people due to a decades-old policy that categorized such treatment as "experimental". That exclusion was eliminated in May 2014, and there is now no national exclusion for transition-related health care under Medicare. This means that coverage decisions for transition-related surgeries will be made individually on the basis of medical need and applicable standards of care, similar to other physician or hospital services under Medicare.

If a transgender beneficiary or member requesting transgender services is identified to be covered by another insurer including Medicare, NEMS MSO requires the provider to bill the member's other health coverage prior to billing NEMS MSO for the covered services.

PROCEDURES

1) A Treatment Authorization Request (TAR) is required to be submitted to NEMS MSO UM for gender affirmation services.
2) Due to the serial nature of surgery for gender affirmation, CPT-4 coding should be specific for the procedures performed during each surgery. The provider should not request a TAR or bill using the general CPT-4 code 55970 (intersex surgery; male to female) or CPT-4 code 55980 (intersex surgery; female to male).
3) MSO UM will request clinical notes from the member's treating providers, including the primary care provider (PCP), treating surgeon, and a qualified licensed mental health professional, such as a licensed psychiatrist, psychologist or other licensed physician experienced in the field, to support a definitive diagnosis of persistent gender dysphoria.
4) The TAR and all clinical documentation are forwarded to the MSO Medical Director or physician reviewer for review. Determination of whether a service requested is medically necessary and/or constitutes reconstructive surgery must be made and documented by the qualified licensed mental health professional and the treating surgeon, in collaboration with the member's PCP.
5) MSO UM may pend the TAR for up to 28 days if required clinical notes and documentations are not received from the member's PCP, treating surgeon, and the qualified licensed mental health professional.
6) If the requested clinical notes and documentations are not provided by the PCP, treating surgeon and the qualified licensed mental health professional, MSO UM may deny the TAR by sending a Notice of Action (NOA) to the requesting provider and the member.
7) If the TAR is approved, but there is no available in-network provider to perform the requested services, MSO Provider Relations will be notified to identify and contact Out-Of-Network (OON) provider(s), to negotiate reimbursement rates and terms, and to sign Letter of Agreement(s) (LOA) prior to delivering the requested services.
8) If a member requesting transgender services is covered by other health coverage (OHC) including Medicare, NEMS MSO requires the provider to bill the member's other health coverage prior to billing NEMS MSO for the covered services.

References:

1. DHCS ALL PLAN LETTER 20-018 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-018.pdf
2. Transgender Services https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/transgender.pdf
3. CMS Informational Bulletin https://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-27-13.pdf
4. Center of Excellence for Transgender Health. Surgical options. Updated June 17, 2016. http://transhealth.ucsf.edu/trans?page=protocol-surgery
5. Aetna Gender Affirming Surgery Policy http://www.aetna.com/cpb/medical/data/600_699/0615.html

Policy 68: Tuberculosis Coverage and Guidelines

POLICY

1. NEMS MSO covers tuberculosis (TB) screening, diagnosis, treatment and follow-up.
2. NEMS MSO providers are required to follow the most current San Francisco TB Control Unit diagnostic and treatment guidelines that are based on those of the CDC.
3. NEMS MSO members and providers refer members who require Direct Observed Therapy (DOT) to San Francisco Department of Public Health.

PROCEDURE

1. The primary care physician is responsible for annual tuberculosis screening of NEMS MSO members. If a member is found to be positive, the Department of Public Health's TB Control Unit will provide consultation, screening, evaluation of NEMS MSO members and contacts with Tuberculosis.

In addition, the TB control until provides trained personnel to assist NEMS MSO members who are eligible for direct observed therapy (DOT) services. TB DOT program staff will provide direct observation of the ingestion of prescribed anti-tuberculosis medications. Elderly and persons with language and/or cultural barriers can also be referred to DOT. In addition, members with memory or cognitive disorders or those too ill for self management can be referred.

This program provides, delivers, and oversees the outpatient treatment of selected patients with active tuberculosis (TB) who meet one of the following criteria:

- Have demonstrated multiple drug resistance (INH and Rifampin)
- Whose treatment has failed or patient has relapsed post treatment
- Have significant functional impairment due to mental illness or substance abuse
- Children and adolescents with active TB
- HIV positive patients
- Admitted to a hospital for TB
- Homeless patients
- Patients who fail to keep appointments
- Referral to TB DOT

NEMS MSO staff and providers forward medical records, consult reports, and appropriate laboratory findings for members who meet the above criteria to the local TB Control Program for evaluation and treatment for DOT services.

A NEMS MSO member who is eligible for DOT services remains enrolled with NEMS MSO. The NEMS MSO and PCP maintain responsibility for coordination of services and for continued medical care.

Tuberculosis Control Program
San Francisco General Hospital
Bldg. 90,

4th Floor (Ward 94)
Telephone: (415) 206-8524
Fax: (415) 648-8369
For current TB screening and treatment guidelines, visit
www.sfdph.org/dph/comupg/oservices/medsvs/tb/tbscreen.asp or www.sfhp.org.

2. NEMS MSO provides case management to members with active TB and coordinates PCP care with DPH TB program. When the member completes DOT for TB, NEMS MSO shall facilitate scheduling follow-up appointments when the member is referred back to the primary care provider.

3. For members not eligible for DOT, PCP is responsible to provide TB therapy for members per TB protocols and maintain written documentation of each patient's adherence to the individual treatment plan.

Policy 69: Utilization Management (UM) System Controls

Per the requirements of NCQA 2020 Standards for Utilization Management (UM), the NEMS Management Services Organization (NEMS MSO) has established policies and procedures to ensure the integrity of UM information that is received, dated, stored, reviewed, and processed.

POLICY

A. NEMS MSO has UM system controls in place to protect data from being altered outside of prescribed protocols. The system controls policy is specific to UM denial notification and receipt. The policy includes the following elements:
   1. Define the date of receipt consistent with NCQA requirements
   2. Define the date of written notification consistent with NCQA requirements
   3. Describe the process for recording dates in systems
   4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate
   5. Describe system security controls in place to protect data from unauthorized modification
   6. Describe how the organization audits the processes and procedures in factors 1-6

PROCEDURE

All UM information is stored in the secured EZCAP system. Changes can only be made under certain circumstances as outlined in this policy. Changes are tracked by the EZCAP system in the Audit Trail Log. NEMS MSO quarterly audits UM cases for compliance.

1. Definition of Date of Receipt

The date of receipt is the date when the NEMS MSO department receives the Treatment Authorization Request (TAR) from the member or the member's authorized representative, even if NEMS MSO does not have all of the information necessary to render a decision. The receipt date is the date NEMS MSO receives the request even if it is received by another department in NEMS MSO.

UM information is received via fax, EZ-NET provider portal, and paper copy.

a. Incoming faxes:
   - Incoming faxes are received through Electronic Right Fax where the received date and time are automatically stamped on the bottom of the fax.
   - The UM Coordinator renames the PDF file with patient's name and uploads the file to EZCAP.
   - The UM Coordinator generates a TAR screen in EZCAP and manually inputs the Requested Date and Time reflecting the electronic stamped date and time on the bottom of the fax.

b. EZ-NET provider portal:
   - The EZ-NET provider portal is part of the EZCAP system where providers can submit TARs directly into EZCAP.

- TARs received via the EZ-NET provider portal will have the Requested Date automatically recorded in the system as shown below.

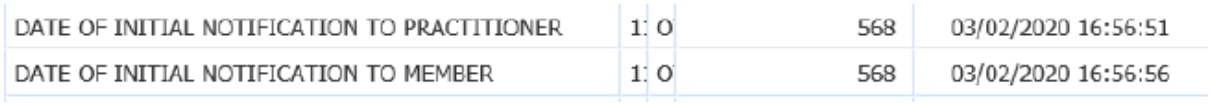
c. Paper documentation:
   - The UM Coordinator writes the received date, time, and their initials on the front page of the paper document. Any documentation that is received on paper should be scanned to make a digital copy, and then saved in EZCAP.

2. Definition of the date of written notification

The UM Coordinator records the date and time of the written notification on the EZCAP notes. It is the date and time when the written notification is sent to the member and provider.

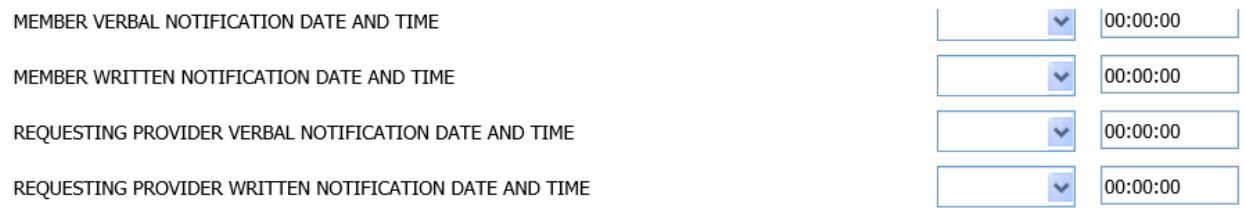
a. Approval letters are automatically generated in the EZCAP system showing the approval decision date.
b. Once the physician reviewer makes a denial decision, the physician reviewer updates the status in EZCAP to "Denied" status. EZCAP records the status change and the change date and time on the EZCAP Audit Trail Log.
c. For cases that are received via the EZ-NET provider portal, the Auth Status History (see below) is shown on the TAR screen and tracked on the EZCAP Audit Trail Log.

d. The UM Coordinator records initial notification to the member and practitioner in EZCAP as below.



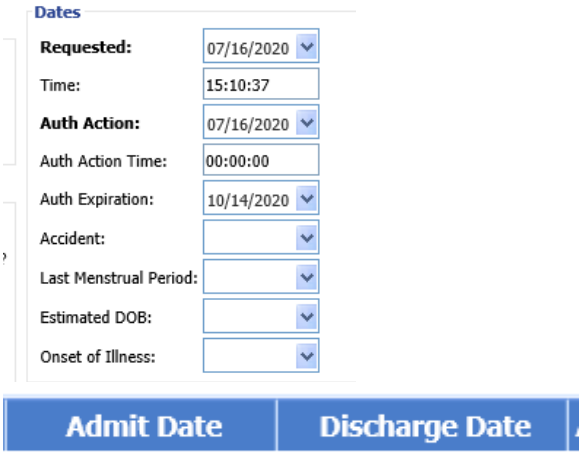
Denial letters are automatically generated in the EZCAP system and printed the next calendar day after decision is made. System captures the ASU date/time as the date printed on the Approval and Denial Notice of Action. The physician is required to input the denial verbiage in the UM note detail section, which will be system-inserted in the NOA denial letter. Verbiage should include the evidence of coverage (if applicable), UM guidelines, and the reason for denial. The UM team mails letters to the member and provider the next business day after decision is made. The date the written notification to member and provider is automatically logged in the system on the Compliance page.

e.



3. Process for recording dates in the system

The UM Coordinator records the requested date and time, auth action date and time, auth expiration date, and date of service in the appropriate fields in EZCAP.



a. Requested Date is the date the authorization was received by NEMS MSO UM. For TAR received via Right Fax, the UM Coordinator inputs Requested Date and Time which reflects the timestamp at the bottom of the fax. For TAR received via the EZ-NET provider portal, the Requested Date is the date the provider submits the TAR which is automatically recorded and tracked.
b. Auth Action Date is the UM decision date – this is the date when an approved or denied UM decision is made. For TAR that requires physician review, the Auth Action Date and Time is updated as soon as possible after the physician reviewer makes the UM decision.
c. Auth Expiration Date is the date when the authorization expires.
d. Admit Date is for retrospective request indicating the initial date of service.
e. In addition to recording the above dates in the EZCAP TAR screen, the UM staff also record all the actions and changes in the EZCAP UM notes.

4. No Modifications

UM team members are not given access rights to make changes to TARs once its status becomes final. Any intentional changes to a TAR's requested date, auth action date (decision date), initial notification date, and written notification date to meet NCQA turnaround time requirement is not acceptable.

The UM team is not allowed to make any changes to the following date fields:

- Auth Action Date is the initial UM Decision Date.
- The initial notification date and the written notification date should not be changed.
- In no circumstances can any UM team member delete a TAR in EZCAP.
- No change can be made to the denial letter including its date after the denial letter is signed by the physician reviewer.

- If inaccurate file is provided by the provider and later received additional information, the additional information is added to the patient's notes. The original is not modified or deleted.

Authorization process for Treatment Authorization Requests (TARs) is outlined below that shows the UM team is not given access to modify authorizations:

1) TARs are reviewed for the following areas:
   a) Member eligibility
   b) Benefit coverage
   c) Medical necessity

2) UM criteria hierarchy are applied:
   a) Medi-Cal/ Medicare
   b) State or Federal Mandates
   c) Health Plan guidelines
   d) MCG Health guidelines
   e) External Review

3) A non-physician UM team member may approve TARs based on clear UM guidelines; only a Physician Reviewer may deny TARs.

4) Documentation of UM criteria used for each TAR is required. The phase "UM Criteria" is input as the Subject line by UM team in EZCAP UM note. UM team writes the appropriate criteria used as specified below to support the approval decision made for the subject TAR in the note detail section:
   a) Med Necessity Met – Medi-Cal
   b) Med Necessity Met – Medicare
   c) Med Necessity Met – MCG
   d) Benefit Coverage
   e) Continuity of Care
   f) 2^{ND} opinion

5) For denials, the physician is required to input the denial verbiage in the UM note detail section, which will be system-inserted in the NOA denial letter. Verbiage should include the evidence of coverage (if applicable), UM guidelines, and the reason for denial.

6) UM team members are not given access rights to make changes to TARs once its status becomes final. There will be no manual changes to TARs in the following fields:
   a) Authorization receipt date
   b) Sponsor decision date
   c) Disposition status

7) To finalize a TAR status from "Requested" or "Open" to "Approve" or "Deny", UM team specifies the authorization status on the "Subject line" of the EZCAP notes. For denials, the physician reviewer is required to input the authorization status.
   a) Status – Approved
   b) Status – Approved Modified

c) Status – Denied
d) Status – Deferred
e) Status – Cancelled
f) Status – Approved with LOA

8) Every 10 minutes, EZCAP is set to capture the authorization status indicated on the Subject line and update the disposition status in the authorization module. This is called Auto-Status-Update (ASU). EZCAP will only capture and update authorization status for TARs with "Open" and "Requested" status. No changes will be made for authorizations with status previously updated to final.

9) Approval and denial letters are automatically generated and printed the next calendar day after decision is made. System captures the ASU date/time as the date printed on the Approval and Denial Notice of Action. No changes can be made to the Letter Creation Date and the letter content.

10) The UM team mails letters to the member and provider the next business day after decision is made. The date the written notification to member and provider is automatically logged in the system on the Compliance page.

11) A report that captures all the letters sent will be generated and signed by the staff member who mailed the letters. The report includes information such as authorization number, approval status, approval/denial date, and the date the letter was sent to provider.

12) In situations where a UM decision is made on the due date that a letter is due or the turnaround time has to be met before a long weekend, the UM staff notifies the System Configuration team on the same day of decision to generate the letter, attach the letter to EZCAP, and record the date of the letters mailed. UM mails the letter on the same day of UM decision.

Cancellation of Authorizations

The UM team does not have any edit rights to cancel an authorization in EZCAP. UM team may receive request from a provider to cancel an authorization.

1) Acceptable reasons for cancellation:

- Provider submitted duplicative requests – the UMC cross reference the two requests
- Requesting provider requests cancellation

2) Unacceptable reasons for cancellation:

- California Children Services (CCS) - If the requested treatment is CCS eligible, the auth is set to "C" – Approved and redirected to CCS. When CCS decision is returned, UMC will document the CCS decision in Memo 4. The decision status does not change and remains in the "C" status.

- No authorization needed – leave the authorization status at "approved" status.

- Member with Other Health Coverage – leave the authorization at "H" status and redirect to primary insurance.

When the acceptable reason for cancellation is met, the UMC completes the Request to Cancel/Modify Authorization in EZCAP Form and document the reason for change (refer to Appendix 8 for the form). The UM Manager, Director of MSO, or Chief of Managed Care reviews the request. If approved for cancellation, the UM team submits the signed form to the Data team to cancel the authorization. The UMC uploads the signed form in EZCAP for record.

5. System Security Control

NEMS has system security controls in place to protect data from unauthorized modifications:

i. Physical access to the system is limited:
   - EZCAP access is limited to MSO staff who needs access for assigned purposes. Password security is required to access EZCAP. The staff's supervisor determines the access rights and levels assigned to each job role. The supervisor is responsible for reporting any changes in roles of specific employees to the MSO System Configuration Analyst who will update staff's access rights.

ii. Unauthorized access and changes to system data is prevented:
   - The EZCAP system requires valid authentication and shall consist of at least a unique user login and password combination to verify user authenticity.
     - Each person who accesses EZCAP must perform that access using unique user identification (login). The login may be a unique name and/or number used to identify and track user identity
     - Staffs are not allowed to use another staff's login. Staffs are not allowed to let others use their login and/or password
     - The use of shared logins is prohibited when accessing EZCAP
     - Any violations of this policy must be reported to the HIPAA Security Officer immediately

iii. Electronic systems are password protected:
   - During new hire orientation, the Provider Relations team informs NEMS MSO staff about the password-protected electronic systems, including requirements to:
     - Use strong passwords
     - Avoid writing down passwords
     - Use different passwords for different accounts
     - Change passwords periodically

iv. Process to alert the Systems Configuration team to change password:
   - To prevent unauthorized access and changes to system data, the MSO System Configuration team is notified of the changing and withdrawing passwords for new hires and terminated staff:
     - <u>Onboarding</u>
       Upon notification from Human Resources of prospective staff joining MSO, the Provider Relations staff shall request the MSO Systems Configuration team to create EZCAP access account for prospective staff to perform functions related to their role. Onboarding notification shall include staff's name, email, title, department, and start date.

- Offboarding
  Passwords of employees who leave the organization are disabled on the day of termination. Upon notification from Human Resources of MSO staff offboarding, Provider Relations shall notify the MSO Systems Configuration team to disable EZCAP account access no later than the last day of employment noted on the offboarding notification. Offboarding notification shall include staff's name, email, tittle, department, and last day of employment.

v. Securing the mailing/paper system
- Faxes are received and sent out from the electronic Right Fax System. The receipt date and time are automatically stamped/recorded and cannot be changed.
- NEMS MSO has established procedures to ensure an appropriate, secure and safe method of handling all mails received and delivered to the local post office or other shipping services. Mail is picked up and sent out every day during business hours of Monday to Friday, except holidays.
- Incoming mail is received, sorted, opened, and stamped by the Provider Relations staff with the date the mail arrives in MSO. Mails are distributed to the appropriate department the same day. In the event that the mail arrives after 4:00 pm, mail will be stamped, sorted quickly for any time-sensitive or urgent mail and distributed the same day. Non-urgent mail that arrives after 4:00 pm may be distributed to the appropriate department the next morning. The UM team uses the date the provider Relations team stamped on the paper document as the receipt date and does not change it.

vi. EZCAP activities are monitored:
- EZCAP activities are monitored by the NEMS MSO Operating Systems Architect who will notify the MSO Director of any deletion or inappropriate use

8. UM Appeal

NEMS MSO is not delegated by Health Plans to perform member or provider UM appeals. The UM staff instructs the member and provider to contact Health Plan for appeal.
Provider may choose to have a peer to peer discussion with the NEMS MSO physician reviewer. The NEMS MSO physician reviewer may reverse the denial decision if additional supporting documentation meeting UM criteria is received. The UM team follows the turnaround time standards as stated in the NEMS MSO UM Program for urgent/routine decisions, initial notification, and written notification. The UM team documents the approval decision in the EZCAP UM notes and updates the Authorization Status to "Approved." The change in the Authorization Status will be automatically tracked on the Audit Trail Log.

Reference:

NCQA 2020 HP Standards and Guidelines, UM 12: UM System Controls

Policy 70: Vaccination Coverage and Flexibility

Influenza vaccination has been shown to have many benefits including reducing the risk of flu illnesses, hospitalizations and even the risk of flu-related death in children. NEMS recognizes the importance to member health and the health care system stability of widespread flu vaccination and prompt provider reimbursement.

POLICY:

1) Flu vaccines are a covered essential health benefit and pursuant to the Advisory Committee on Immunization Practices (ACIP), a preventive service with no cost-sharing requirement.

2) Members may obtain flu vaccines at in-network or out-of-network providers.

3) Prior authorization for flu vaccine is not required for payment.

PROCEDURE:

1) NEMS does not require prior authorization for flu vaccines. Members may obtain flu vaccines at in-network or out-of-network providers.

2) When UMC receives a TAR for flu vaccine, UMC educates the requester about no prior authorization requirement for flu vaccine.

3) MSO Claims department will provide timely reimbursement of provider claims on flu vaccination. UMC will notify MSO Claims the same day they are notified by a provider of any claims issue pertaining to flu vaccination.

References:

1) Centers for Disease Control and Prevention (CDC): Key Facts About Seasonal Flu Vaccine 2021

2) DMHC APL 20-37: Vaccinations; Coverage and Flexibility

Policy 71: Vaccines for Children (VFC)

The Vaccines for Children (VFC) program was designed to help raise childhood immunization levels by providing free vaccines to physicians for eligible children. Children eligible to receive VFC must be 18 years of age or younger and:

- Eligible for Medi-Cal or CHDP; or
- Have no health insurance; or
- American Indian or Alaskan Native, as defined by the Indian Health Services Act; or
- Children who have health insurance that does not cover immunizations

Currently, the vaccines and/or combination vaccines offered by the VFC Program are:

- Haemophilus influenzae type b (Hib)
- Hepatitis A
- Hepatitis B
- Influenza
- MMR (Measles, Mumps, Rubella)
- PCV7
- Poliomyelitis
- Varicella
- DTaP (Diphtheria, Tetanus, Pertussis)
- Pediarix (IPV, DTaP, Hepatitis B)
- Comvax (Hib, Hepatitis B)
- Td (Tetanus, diphtheria)
- Meningococcal
- HPV
- Tdap (Tetanus, diphtheria, pertussis)
- Rotavirus

Ordering Vaccines

To order vaccines, the Pediatric nurse in charge will complete and submit a VFC Vaccine Order form to the VFC Program office.

Handling of Vaccines

Proper handling of vaccines after delivery is essential for ensuring that the vaccine is effective and will protect the patients who receive them.

- Vaccines are stored according to manufacturer requirements.
- Never reject the delivery of VFC vaccines, even if the delivery of the vaccines may have been delayed or may not have been maintained at the recommended temperatures. Contact the VFC Program for information on what to do with the vaccine.
- Never discard or return vaccine without prior approval of the VFC Program.

Policy 72: Waiver Programs and Community Resources

POLICY

The NEMS MSO case manager will coordinate the care of adult members who are candidates for State Department of Health Services-administered Medi-Cal Home and Community-Based Waiver Programs and facilitate transfer of care from NEMS MSO to appropriate waiver programs. These waiver programs provide in-home care as alternatives to acute hospital or institutional care.

PROCEDURE

1. Health plan provides NEMS MSO and providers with information on the eligibility criteria for waiver programs through its provider manual and updates the information based on State and local program changes as needed.
2. PCPs, NEMS MSO case managers, and participating hospital discharge planners identify members who are under their care who are eligible for Medi-Cal Home and Community-Based Care Waiver Programs.
3. NEMS MSO identifies potential candidates for referral to Medi-Cal Home and Community based care waiver programs via case managers, whose responsibilities include:
    - Conducting concurrent in-patient reviews to identify members who meet the general criteria for the Medi-Cal Home and Community-Based Care Waiver Programs and would benefit from in home, supportive care programs. Reviewing cases being managed on an out-patient basis who are identified by NEMS MSO providers as candidates for such program.
    - Assessing the needs, functional limitations and socioeconomic status of identified members. Case Managers also assess the member's medical status, health history, psychosocial needs, home environment, and formal/informal support systems.
    - Collaborating with the member's PCP and facility discharge planner to determine the nature of supportive services required.
    - Determining the Waiver Program site/slot availability.
    - Contacting the appropriate Waiver Program to determine availability of required services. Refer to the health plan's Community Resource Guide for contact information.
4. NEMS MSO case manager will discuss with member and/or family application for waiver program participation. Written consent from member for referral is obtained (for AIDS/ARC Waiver Program). NEMS MSO case manager is assigned to follow member at the time referral to a waiver program.
5. Coordination and collaboration between NEMS MSO case manager, PCP and the referred program, including referral to the program, is documented in the member's record.
6. Health plan provides case management services to verify member eligibility status and facilitate NEMS MSO's communication with Waiver Programs. In cases when NEMS MSO case managers are having difficulty communicating with the appropriate Waiver programs, NEMS MSO case manager will notify health plan. Health plan provides follow-up on waiver program eligibility status for members.

7. PCP provides medical records to the Waiver Program, upon request, when members are referred and enter care. Transfer of records shall be in accordance with State law and professional practice standards and in accordance with NEMS MSO confidentiality procedures.
8. The patient may have dual membership in health plan and the Waiver Programs. The NEMS MSO will manage the care of the patient after enrolling in the waiver programs.

Waiver Programs and Community Resources

- **Breast Pump and Lactation Services**

NEMS MSO provides new mothers with free electric breast pumps, lactation supplies, counseling, and human breast milk if medically necessary. These services require a provider's prescription. Services are free for the first 60 days, but may be continued if medically justified. For more information, call NEMS MSO at (415) 352-5045.

- **California Children's Services**

California Children's Services (CCS) provides special medical care for children less than 21 years of age who have physical disabilities and complex medical conditions. Refer to Policies and Procedures "California Children's Services".

- **Comprehensive Perinatal Services Program (CPSP)**

The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal reimbursement program that funds a wide range of services for pregnant women, from conception through 60 days postpartum. Refer to Policies and Procedures "Comprehensive Perinatal Services Program".

- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**

EPSDT provides the following services to qualified persons under 21:

- Routine well child checks through the Child Health and Disability Prevention Program
- Diagnosis and treatment for persons with specific medical conditions
- Private duty nursing
- Physical, occupational and speech therapies
- Pediatric day health care facilities

For more information call San Francisco Children's Medical Services at (415) 575-5700.

- **TB/Direct Observed Therapy (DOT) for the Treatment of Tuberculosis**

The primary care physician is responsible for annual tuberculosis screening of NEMS MSO members. If a member is found to be positive, the Department of Public Health's TB Control Unit will provide consultation, screening, evaluation of NEMS MSO members and contacts with Tuberculosis. Refer to Policies and Procedures "Tuberculosis Coverage and Guidelines".

- **Early Start**

Infants and children under three years of age who have a developmental delay or disability or an established risk condition with a high probability of resulting in a delay may be eligible to receive early intervention, or "Early Start", services in California through Golden Gate Regional Center.

All infants and toddlers suspected of having a developmental concern including those "at risk" will receive intake and evaluation from their local regional center to determine eligibility for services. Regional centers will facilitate each family's access to local Family Resource Center's Prevention Resource & Referral Services.

Eligible children for Prevention Resource & Referral Services are ages birth through 35 months, who are at substantially greater risk for a developmental disability but who would otherwise be ineligible for services through the Early Start Program newly referred families whose infants or toddlers are "at risk" for developmental delay or disability will receive the following services through Family Resource Centers (FRCs):

- Information
- Resources
- Referrals
- Targeted outreach

Infants or toddlers under 3 years of age with solely a visual, hearing, or severe orthopedic impairment, may be eligible to receive early intervention, or "Early Start" services in California through their local educational agency.

Early Start provides a wide range of services including speech therapy. For a list of Early Start services, visit Golden Gate Regional Center at www.ggrc.org.

The NEMS MSO and PCP are responsible for coordination of services with the Early Start Program and financially responsible for covering the initial evaluation and two speech sessions per month. Speech therapy sessions in excess of two per month and other therapy services may be covered by the Early Start Program. A NEMS MSO member who is eligible for Early Start services remains enrolled with NEMS MSO, and the NEMS MSO and PCP maintain responsibility for coordination of services and for continued medical care.

NEMS MSO PCP and case managers may refer to Early Start by contacting:
Golden Gate Regional Center

875 Stevenson Street, 6th Floor
San Francisco, CA 94103 (415)
546-9222

Additional information about the Early Start Program can be found at
www.dds.ca.gov/earlystart

- **Genetically Handicapped Persons Program (GHPP)**

GHPP is a state-funded program that coordinates care and pays medical costs for eligible persons age 21 years old or older with genetically-transmitted diseases such as hemophilia, cystic fibrosis, and sickle cell disease, as well as metabolic disorders such as

Phenylketonuria (PKU). For more information, call (916) 327-0470 or (800) 639-0597 or visit their website at www.dhs.ca.gov/pcfh/cms/ghpp/.

- **Golden Gate Regional Center**

Golden Gate Regional Center (GGRC) is a nonprofit private corporation that contracts with the State Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. According to Title 17, Section 54000 of the California Code of Regulations, a "Developmental Disability" is defined as a disability that is attributable to

- Mental retardation;
- Cerebral palsy;
- Epilepsy;
- Autism; or
- Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

To be eligible for services, a person must have a disability that begins before the person's 18th birthday, be expected to continue indefinitely and present a substantial disability as defined in Section 4512 of the California Welfare and Institutions Code. Eligibility is established through diagnosis and assessment performed by regional centers.

Some of the services and supports provided by the regional centers include:

- Information and referral
- Assessment and diagnosis
- Counseling
- Lifelong individualized planning and service coordination
- Purchase of necessary services included in the individual program plan
- Resource development
- Outreach
- Assistance in finding and using community and other resources
- Advocacy for the protection of legal, civil and service rights
- Early intervention services for at risk infants and their families
- Genetic counseling
- Family support
- Planning, placement, and monitoring for 24-hour out-of-home care
- Training and educational opportunities for individuals and families
- Community education about developmental disabilities

NEMS MSO is not financially responsible for the GGRC services provided to its members. A NEMS MSO member who is eligible for GGRC services remains enrolled with NEMS MSO, and NEMS MSO and PCP maintain responsibility for coordination of services and for continued medical care.

Medical group physicians can refer to GGRC by contacting:
Golden Gate Regional Center (San Francisco County)

1355 Market Street, Suite #220
San Francisco, CA 94103
(415) 546-9222

For additional information, visit the GGRC website at www.ggrc.org.

- **HIV Counseling, Education, and Testing**

San Francisco City Clinic provides confidential HIV counseling, education, testing and follow-up services. Infants, children, and adolescents under age 21 who are confirmed HIV positive may be eligible for CCS. For more information on HIV Counseling, Education and Testing contact San Francisco City Clinic at (415) 487-5500 or visit www.sfcityclinic.org.

- **HIV/AIDS Waiver Program**

This program provides Medi-Cal recipients with a written diagnosis of symptomatic HIV or AIDS with case management, in-home skilled nursing care, home-delivered meals, and non-emergency transportation. Qualified persons *cannot* be simultaneously enrolled in either the Medi-Cal hospice or the AIDS Case Management Program. For more information, call West Side Community Services at (415) 355-0311, Option 8 or www.westside-health.org.

- **Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver**

HCBS-DD is one of six waiver programs available to Medi-Cal members. The purpose of this program is to provide in-home care and support to persons with disabilities. Services provided include: homemakers for chores, home health aides and/or nurses, family training, vehicle adaptation, respite care, day habitation, transportation and more. For referral and eligibility review contact Golden Gate Regional Center at (415) 546-9222. For more information, visit www.dhcs.ca.gov/services/ltc/Pages/DD.aspx.

- **Local Education Agency**

The San Francisco Unified School District's Local Education Agency (LEA) provides special education services for eligible children 36 months or older with one or more of the following conditions:

  - Vision or Hearing Impairment
  - Orthopedically Challenged
  - Developmentally Delayed

Referrals by PCP or NEMS MSO Case Manager can be made directly to SFUSD Special Education office at (415) 759-2222 or the Pre-K Intake Unit at (415) 401-2525 x1101 for children ages 3-5.

Refer to Policies and Procedures "Local Education Agency".

- **Multipurpose Senior Service Program (MSSP)**

The Multipurpose Senior Service Program (MSSP) provides in-home care to members as an alternative to placing them in an institution. The County's Department of Aging administers the program. Services are available to physically disabled or aged members

over 65 years of age who would otherwise require care at skilled nursing facility (SNF) or intermediate care facility (ICF) level. MSSP assists with a wide array of services that include:

- Personnel (nurses, home health aides, social workers, senior companions)
- Home Safety Modifications
- Legal Assistance
- Meal Delivery
- Housing
- Counseling and Crisis Intervention
- Transportation
- Assistance with Eviction or Elder Abuse
- Respite Care

NEMS MSO staff and physicians identify and refer potentially eligible members to the MSSP for evaluation who are:

- Aged 65 years or older
- Eligible for Medi-Cal
- Residents of San Francisco

The NEMS MSO staff and physicians case manage and assist with the coordination and communication of services between the MSSP and Adult Day Health Care Center. Services provided under the MSSP program are reimbursed by the San Francisco County Department of Aging. NEMS MSO is not financially responsible for the MSSP services provided to its members. A NEMS MSO member who is eligible for MSSP services remains enrolled with NEMS MSO. The medical group and PCP maintain responsibility for coordination of services and for continued medical care.

The PCP or specialist submits appropriate medical records and the MSSP referral to:
Institute on Aging for Multipurpose Senior Service Program and Adult Day Health Care 3626 Geary Boulevard, Second Floor
San Francisco, CA 94118
(415) 750-4150 or (415) 750-5330
www.ioaging.org
San Francisco Adult Day Services Network at (415) 808-7371 or www.sfadultday.org.

- **Nursing Facility Waiver Program**

Nursing Facility Waiver services are provided to Medi-Cal recipients of any age who need in-home assistance with activities of daily living, protective supervision, private duty nursing, environmental adaptation, and case management. For more information, call (916) 552-9400.

- **Sexually Transmitted Infections (STI) Testing**

NEMS MSO provides confidential STI prevention, screening, diagnosis, treatment, and counseling. Services for NEMS MSO members do not require prior authorization or referral from their primary care provider. Anyone 12 years and older may obtain STI testing services without parental consent or disclosure. For more information, call the San Francisco City Clinic at (415) 487-5500 or visit their website at: www.sfcityclinic.org.

- **Women, Infants, and Children (WIC)**

Women, Infants and Children (WIC) is a nutrition/food program that helps women who are pregnant, breastfeeding or have recently had a baby, and children under the age of five to eat well and stay healthy. WIC eligibility is determined by federal income guidelines. Medi-Cal and many Healthy Kids members are eligible. Services include free food vouchers, nutrition education and breastfeeding support. WIC eligible members must be referred by their PCP or OB-GYN. WIC uses federal income guidelines to determine who is clinically and financially eligible.

NEMS MSO is not financially responsible for any of the WIC services provided to its members. A NEMS MSO member who is eligible for WIC services remains enrolled with NEMS MSO, and NEMS MSO and PCP maintain responsibility for coordination of services and for continued medical care for members enrolled in WIC.

NEMS MSO and PCP can refer to WIC in a number of ways:

- By calling (888) WIC-WORKS or (888) 942-9675 for an appointment or in San Francisco (415) 575-5788
- By visiting their website at http://www.sfdph.org/dph/comupg/oprograms/PHP/WIC/WIC.asp
- By referring members to any WIC Center (See WIC Brochure for current locations)

Policy 73: System Automatic Approval (AA) – Contracted Providers

POLICY
In an effort to reduce the administrative and time burden of contracted providers and under discretion of the UM team, the UM team may set automatic system approval of prior authorization requests meeting certain criteria when made to contracted providers. These criteria include certain procedure codes that are commonly requested and have historically have a close to 0% denial rate.

The auto approval criteria is decided by the UM Team and communicated with the system configuration team for set up. The auto approval criteria must be decided for each line of business. Prior to configuration, the UMP and protocol needs to be in place before the rule goes live in the EZCAP system.

System Automatic Approval Rules are listed in Appendix 9.

2022 Medi-Cal Utilization Management Program
North East Medical Services

Signature Page

Review and approval of the attached Policies and Procedures performed by:

APPROVED _____ DATE 02/03/2022
Katrina Liu, MD
MSO Medical Director

APPROVED _____ DATE 02/03/2022
Linda Tang
Chief Managed Care Officer

Appendix 1: Interrater-Reviewer Reliability Audit Tool for Non-Physician Reviewer (UM Coordinator and Nurse)

Use 8/30 rule and one page per UM staff member

Non-Physician Reviewer Audited:

Date of Audit:

Audit Completed by:

Case #																													
	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA
1. Correct procedures & specialists authorized																													
2. Criteria hierarchy was followed and documented (Medi-Cal, SFHP, MCG)																													
3. Medical criteria were applied correctly																													
4. Decision was made within time frame standard																													
5. Provider notified within time frame standard																													
6. Member notified within time frame standard																													
7. NOA sent to member and provider within time frame standard																													
8. NOA language is clear and concise and written at 6th grade level																													
9. Documentation is complete - included received date, date provider and member notified, date NOA sent, and clinical info documented to support determination																													
Total for this Coordinator																													

Appendix 1: Interrater-Reviewer Reliability Audit Tool for Non-Physician Reviewer (UM Coordinator and Nurse)

Use 8/30 rule and one page per UM staff member

Non-Physician Reviewer Audited:

Date of Audit:

Medical Charts Date:

Audit Completed by:

Case #																													
	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA	YES	NO	NA
1. Correct procedures & specialists authorized																													
2. Criteria hierarchy was followed and documented (Medi-Cal, SFHP, MCG)																													
3. Medical criteria were applied correctly																													
4. Decision was made within time frame standard																													
5. Provider notified within time frame standard																													
6. Member notified within time frame standard																													
7. NOA sent to member and provider within time frame standard																													
8. NOA language is clear and concise and written at 6th grade level																													
9. Documentation is complete - included received date, date provider and member notified, date NOA sent, and clinical info documented to support determination																													
Total for this Nurse Reviewer																													

Appendix 2: Interrater-Reviewer Reliability Audit Tool for Physician Reviewer

Use 8/30 rule and one page per UM staff member

Physician Reviewer Audited:

Medical Charts Date:

Date of Audit:

Audit Completed by:

Auth#																													
1. Medical records are sufficient to support the decision																													
2. Appropriate guidelines were used																													
3. Criteria hierarchy was followed (Medi-Cal, SFHP, MCG)																													
4. Medical criteria were applied correctly (denied appropriately)																													
5. Discussed with requesting physician as needed before denial																													
6. Consulted a specialist or external medical review as needed.																													
7. Decision was made timely																													
8. Denial letter was clear and concise and written at 6th grade level																													
9. Denial letter signed timely																													

Total for this physician

Appendix 3: Affirmative Statement about Incentives

Affirmative Statement about Incentives

I,_____acknowledge the following:

1. UM decision making is based only on appropriateness of care and service and existence of coverage.

2. NEMS does not specifically reward practitioners or other individuals for issuing denials of coverage.

3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Signature: _____

Title or Job Duty: _____

Date: _____

NEMS MEDICAL GROUP AUTHORIZATION GUIDELINES
MEDI-CAL MANAGED CARE PLANS

NEMS Medical Group performs administrative services for members who are enrolled in the Medi-Cal managed care plan and selected a primary care provider in the NEMS Medical Group.

Authorization Required	No Authorization Required
✓ Acupuncture ✓ Allergy Injections ✓ Ambulatory Surgery Services ✓ Audiological Services ✓ Bone Density Studies ✓ Chemical Dependency Services ✓ Chemotherapy ✓ Chiropractic ✓ Colonoscopy / Sigmoidoscopy (diagnostic) ✓ CT Scans / MRI / PET Scans ✓ Cardiac non-invasive test ✓ Custodial Care ✓ Durable Medical Equipment (DME) ✓ Elective Sterilization ✓ Electric Breast Pump (hospital grade) ✓ Gamma Immune Therapy ✓ Gender Reassignment ✓ Genetic Testing ✓ Hearing Aids ✓ Home Health Care / Home Infusions Services ✓ Hospice Care for general inpatient level of care ✓ Hospital Admission ✓ Laboratory Procedures costing over $300 ✓ Nuclear Medicine Studies ✓ Obstetric Procedures (include amniocentesis / more than 1 ultrasound) ✓ Office Procedures costing over $300 ✓ Outpatient Hospital Procedures (include imaging and other ancillary services done in the out-patient hospital setting) ✓ Renal Dialysis ✓ Sleep Studies ✓ Specialist to Specialist Referrals ✓ Skilled Nursing and Intermediate Care ✓ Surgeries ✓ Therapy Services (include PT, OT, Speech) ✓ Transplant	➢ **Sensitive Services** – Medi-Cal members may self-refer to any providers for pregnancy testing, family planning services, HIV testing, abortion services, and treatments of sexually transmitted diseases ➢ **Abortion Services** – Outpatient services do not require prior authorization, unless hospitalization is needed ➢ **EPSDT/CHDP services** provided by PCP, FQHC, community clinic, DPH per EPSDT/CHDP periodicity schedules and guidelines ➢ **OB/GYN Services** – A member may self-direct to in-network providers for obstetrical and gynecological services ➢ **Tuberculosis Care** – Tuberculosis screening, testing, and treatment, do not require prior authorization, unless hospitalization is needed ➢ **Well Woman Care** – Services provided according to ACOG guidelines with emphasis on preventive screening, including routine Pap smear, breast exam, and mammography, do not require prior approval ➢ **Hospice Care (Outpatient)** - Authorization is not required for routine home care, continuous home care, respite care, custodial care, or for hospice physician services ➢ **Preventive Care Screening –** Screening colonoscopy/sigmoidoscopy, cervical cancer screening, breast cancer screening --- **<u>Authorizations for the below services are not processed by NEMS MSO</u>** Please contact the entities responsible for the following services: • **Mental Health (inpatient):** For inpatient or specialty mental health, contact the county mental health department. o San Francisco County Behavioral Health: o San Santa Clara County Behavioral Health: 1-800-704-0900 • **Mental Health (outpatient):** For mild to moderate behavioral health, contact the health plan's mental health benefit administrator. o Anthem Blue Cross: 1-888-831-2246 o San Francisco Health Plan: Contact Beacon Health Options at 1-855-371-8117 • **Vision:** Call VSP Vision Care (VSP) at 1-800-438-4560 • **Dental:** Call Denti-Cal at 1-800-322-6384

Important Notice:

1) NEMS MSO reserves the right to review and modify authorization requirement based on established criteria and/or community standards of practice
2) Payment is contingent upon eligibility at the time of service
3) Provider is responsible to verify member eligibility prior to rendering services

NEMS NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心
Management Services Organization (MSO)
2171 Junipero Serra Boulevard, Suite 600
Daly City, CA 94014
Phone (415) 352-5186 Fax (415) 398-2895

TREATMENT AUTHORIZATION FORM

Type of Request:
☐ Routine ☐ Urgent ☐ Retro

Member Information	Name:_____ Date of Birth:_____ Member ID #:_____
Requesting Provider	Name:_____ Phone #:_____ Fax #:_____
Rendering Provider	Provider Name:_____ NPI:_____ Specialty:_____ Facility:_____ Contact Person:_____ Phone #:_____ Address:_____ Fax #:_____

Diagnosis Description 1: _____ **ICD-10:** _____
Diagnosis Description 2: _____ **ICD-10:** _____
Diagnosis Description 3: _____ **ICD-10:** _____
Diagnosis Description 4: _____ **ICD-10:** _____

Type of Service: ☐ Inpatient ☐ Outpatient ☐ Office ☐ DME ☐ Home ☐ Other: _____
Date of Service: _____

For Completion by Referring Provider

Specific Services Requested	Procedure Code (CPT code)	Units of Service	Specific Services Requested	Procedure Code (CPT code)	Units of Service
1.			4.		
2.			5.		
3.			6.		

Medical Justification: *(copy of related medical records/x-ray/lab reports - attach as necessary)*

I certify that the above requests are medically necessary in the care of this patient.

Referring Provider Signature:_____ **Date:**_____

Important Note: *Payment is contingent upon eligibility at the time of service. Providers are responsible for checking patient eligibility prior to rendering services by verifying eligibility directly with member's health plan. Payment to non-contracted/out-of-network providers is based on the current CMS Medicare or DHCS Medi-Cal fee schedule according to member's eligibility at the time of service.*

For NEMS-MSO Use Only

☐ **Approved** ☐ **Modified** ☐ **Denied** ☐ **Deferred**

Comments:

By: _____ Date: _____ Date faxed: _____

Member Name: _____ PCP Name: _____

DOB: _____ PCP Phone #: _____

Health Plan ID: _____ Follow-up Appt Date: _____

Date: _____ Date PCP Notified of Discharge: _____

Appendix 6: Discharge Planning Checklist

The Utilization Management (UM) Coordinator works closely with the hospital discharge planner and member/caregiver for a safe discharge to an alternative care setting. The UM Coordinator assesses the following areas:

1. What is the pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received?

2. Was the patient independent prior to admission?

3. Will this current episode of illness impact the patient's independence? Short term or long term?

4. Does the member/caregiver understand the medical condition?

5. What is the current medical condition?

6. What is the current mental condition?

7. Are there any financial difficulties?

8. Does the member have problems getting food?

9. Does the member have social supports to manage any loss of independence?

10. Does the member have adequate resources to provide for post discharge (Hospital, Nursing Home, Certified Home Health Agency) needs, such as medications, equipment, rehab, or follow up treatment?

11. Does the member have adequate insurance coverage, e.g., Medicare, Medi-Cal, private insurance, and veterans?

12. Has this patient had multiple hospital admissions or emergent care use? (Refer to Case Management)

13. Is there a history of non-compliance, which impacts the ability to be managed at home?

14. What is the patient's living arrangement? (Home, apartment, with family, congregate living, homeless, stairs to enter, wheelchair accessibility, functional plumbing, heat, cooking facilities…)

Member Name: _____ PCP Name: _____
DOB: _____ PCP Phone #: _____
Health Plan ID: _____ Follow-up Appt Date: _____
Date: _____ Date PCP Notified of Discharge: _____

15. What is the most appropriate placement setting?

____ Acute hospital ____ Subacute ____ SNF ____ Home
____ Inpatient hospice ____ Home hospice ____ Board and Care ____ Respite

16. Are there any anticipated problems in implementing post-discharge plans?

Issues Identified:

_____ Multiple diagnosis and co-morbidities
_____ Impaired Mobility
_____ Impaired self-care skills
_____ Poor cognitive status
_____ Catastrophic injury or illness
_____ Homelessness
_____ Poor social supports
_____ Chronic illness
_____ Anticipated long term health care needs (e.g., new diabetic, CHF)
_____ Substance abuse
_____ History of multiple hospital admissions
_____ History of multiple emergent care use
_____ Non-compliance with treatment
_____ Low health care literacy
_____ Other _____

Interventions:

_____ Skilled nursing facility/other institution transfer
_____ Transportation from hospital to home/facility
_____ Home care referral
_____ DME referral
_____ PCP referral
_____ Specialty referral
_____ Social worker referral
_____ Case management referral
_____ Paratransit application
_____ Education material mailed
_____ Care coordination with CCS, GGRC, Early Start, and LEA
_____ Other _____

NEMS NORTH EAST MEDICAL SERVICES 東 北 醫 療 中 心
MANAGEMENT SERVICES ORGANIZATION (MSO)

Request to Cancel/Modify Authorization in EZCAP

Requestor and Authorization Information	
UM Coordinator:	
Request Date:	
Authorization Ref #:	

Requested Change	
Cancel Authorization:	☐ **Duplicate Authorization** Ref # of Duplicate Auth #: _____ ☐ **Requesting Provider Requests Cancellation** Staff spoken to: _____ Date & Time: _____ Reason: _____
Modify Authorization:	☐ **Update Admit Date to:** _____ Reason: ☐ Anticipated SNF admit date changed ☐ Other: _____ ☐ **Update Admit Type to:** _____

Request Review *(To be filled out by UM Manager, MSO Director, and/or Chief of Managed Care)*			
Decision:	☐ Approve ☐ Deny		
Reviewer:			
Review Date:		Signature:	

Systems Team: EZ-CAP Update *(To be filled out by Systems Team)*	
Change Made By:	
Date of Change:	
Details of Change:	

2022
CONIFER VALUE-BASED CARE UTILIZATION MANAGEMENT PROGRAM

2022
CVBC CONIFER VALUE-BASED CARE
UTILIZATION MANAGEMENT PROGRAM
TABLE OF CONTENTS

UTILIZATION MANAGEMENT PROGRAM

1. UTILIZATION MANAGEMENT PROGRAM MISSION STATEMENT

The mission of the Utilization Management Program (UMP) is to assure the delivery of medically necessary, achievable, quality patient care through the consistent delivery of health care services by providing and managing a coordinated, comprehensive, quality health care network in the service area, without discrimination based on health status and in a culturally competent manner.

2. PURPOSE

The purpose of the Utilization Management Program is to provide a comprehensive framework for the provision of high quality, cost effective medically appropriate healthcare services in compliance with patient benefit coverage, and in accordance with the requirements of the contracted payers, the National Committee for Quality Assurance (NCQA), Department of Health Services (DHS), Department of Managed Health Care (DMHC), and local, state and federal regulations. The UM Program ensures authorized services are timely, medically necessary and appropriate, delivered at appropriate levels of care and consistent, to ensure services are not over or under-utilized. The Utilization Management Program applies to all Medical Groups and IPAs managed by Conifer Value Based Care (CVBC).

3. GOALS

The goal of the Utilization Management Program (UMP) is to ensure the timely delivery of medically necessary medical and behavioral health care services to patients and appropriate utilization of resources. The program will ensure efficiency and continuity in this process by identifying, evaluating, monitoring, and correcting elements that affect the overall effectiveness of the utilization management process. The program's activities are developed and implemented in compliance with Health Plan Contracts, state and federal regulations. This program is integrated with the Quality Improvement (QI) Program, which promotes objective, systematic monitoring and evaluation of appropriate resources throughout the continuum of care.

The goals of the UMP are as follows:

1. Provide a system to ensure that medical services are delivered at the appropriate level of care in a timely manner.

2. Continually monitor, evaluate, and optimize healthcare utilization resources by applying Utilization Management policies and procedures to review medical care and services.

3. Monitor both inpatient and outpatient care for possible quality of care

Deficiencies and utilize referral indicator screening criteria. All potential deficiencies are documented and submitted to the Quality Improvement Committee.

4. Educate contracted practitioners on the policies and procedures of Utilization Management (UM) to ensure compliance with the policies, procedures, goals, and objectives of the Utilization Management Program**.**

5. Assure governmental payers and other regulatory agency guidelines, standards and criteria are adhered to, when applicable.

6. Comply with Federal laws and requirements, including the Civil Rights Act, ADA, Age Discrimination Act, and Federal Funds Laws.

7. Monitor utilization practice patterns of contracted practitioners to identify variations.

8. Conduct medical review of all potential denials of services.

9. Provide all medically necessary care within the contracted provider network and coordinate care for services rendered out of network.

10. Identify high-risk members and ensure appropriate care is rendered through comprehensive case management.

4. OBJECTIVES

The UMP's objectives are designed to provide mechanisms that ensure the provision of timely quality healthcare services and optimize opportunities for process improvement through:

1. Develop, update, and implement Utilization Management Policies and Procedures to ensure compliance with all contracts, State, Federal and NCQA requirements.

2. Collect, track, analyze, and compare utilization data statistical information against benchmarks for identification improvement opportunities.

3. Develop, coordinate and monitor an internal system, which ensures the identification of quality of care issues, and management of the interface for referring the quality of care issues from Utilization Management to Quality Improvement.

4. Trend and share utilization data with practitioners through UM Committee meetings and provider office forums as a method of educating practitioners.

5. Develop and implement a monitoring system to track over/under utilization of services.

6. Track and monitor referral turnaround time against requirements.

7. Identify areas for Utilization Management improvement from practitioner and member surveys.

8. Document medical review for all hospitalized and skilled nursing patients, and integrate established Health Plan Care Management Programs into the existing Case Management Program.

9. Initiate discharge planning prior to, or on the day of, the hospital admission by identifying the individual needs of those members, which will facilitate a timely discharge to a lower level of care with efficiency.

10. Coordinate care of members with Health Plans, based on contract delegation, for inpatient and outpatient services.

11. Expand existing Case Management Program to include Disease State Management in coordination with QI.

5. ORGANIZATIONAL STRUCTURE, AUTHORITY AND ACCOUNTABILITY

5.1 Organizational Structure

The UMP represents the combined efforts of a multidisciplinary team of licensed and non-licensed professionals. The program functions are under the direction of a Medical Director who has an un-restricted license to practice Medicine in California. The Medical Director assures that all decisions are based on medical necessity, appropriateness, and quality and benefit limitations. No decisions are made based on financial incentives and the staff is not compensated based on services denied.

5.2 Board of Directors

Each Medical Group/IPA has a governing body or Board of Directors, which has delegated the authority and responsibility for oversight of the UMP to the UM Committee. The CVBC Medical Director has the accountability to ensure that an effective program is established, maintained, and supported. The CVBC Medical Director works closely

with the UM Chair and Board of Directors to ensure that the UM activities are effective.

5.3 UM Committee Structure

The UMC meetings are led by the UM Chairperson, who is a physician from the Medical Group/IPA and actively practices medicine. If the UM Chair is unable to attend, another Medical Group/IPA committee member may lead the meeting.

The UMC reports its activities to the Board of Directors on a quarterly basis.

Membership includes physicians from the IPA/Group, IPA Services Representatives, and other specialists ad hoc. A senior level physician is designated to be involved in the implementation of the UM process and is actively involved in implementing the UM program. Health plan UM staff may attend UMC with advance notice to observe and do not have voting rights. The CVBC Medical Director and CVBC Director of Care Coordination may attend the UMC meeting as needed or as requested by the IPA/Group but are not required to regularly attend.

Voting privileges are restricted to physicians who are members of the UMC.

A Quorum consists of a simple majority (50%+1) of voting members or at least three (3) Physician Committee members, which may include the CVBC Medical Director.

UMC will meet at least quarterly for a minimum of four times a year. Members and guests attending the UMC meetings are required to sign statements acknowledging confidentiality and such statements are signed annually.

5.4 Minutes

All meetings of the UMC are formally documented in transcribed minutes, which will include discussion of each topic, action plan and/or follow-up requirements. All minutes will be considered confidential. Draft minutes of a prior meeting are reviewed and approved as read or with correction.

5.5 Authority

The minutes of UMC and all recommendations and actions taken at the UMC are presented to the Board of Directors for final approval.

5.6 UMC Functions

The UMC is responsible for the overall direction and development of strategies to manage the UMP. The responsibilities of the UMC include but are not limited to the following activities:

- Review of medical necessity
- Ensure appropriate allocation of resources
- Develop and implement processes to improve quality of care and compliance with contractual and regulatory requirements through the review and analysis of UM data
- Review and evaluate and update the UMP annually, as necessary
- Review and approve of all UM policies and procedures annually and revisions as necessary
- Analyze aggregate and physician specific UM data for identification of patterns and trends with recommendations to the Board of Directors
- Monitor over/under utilization
- Annual review of Inter-Rater Reliability (IRR) studies to ensure consistency of application of medical criteria or guidelines used for decision making
- Review and approve of medical criteria and clinical practice guidelines
- Review of new medical technology through medical technology assessments as determined by the health plan
- Monitor pharmacy utilization through review and analysis of pharmacy data as provided by health plan
- Monitor effectiveness of the medical management process through member and provider satisfaction surveys. The survey results will be included in a summary for review and analysis by the UMC, including a comparison to the previous year's results. Corrective actions to improve survey results will be monitored by the UMC.

The term of membership is for one year, with a possibility of two years' reappointment.

5.7 UM Committee Composition

A minimum of 2 practitioners (primary care and specialty practitioners), UM coordinator and/or other administrative personnel must compose the committee. Practitioner consultants from appropriate specialty areas of medicine and/or additional specialty sources and organizations are available to review cases pertaining to their specialty. Behavioral health care practitioner is involved if the IPA/Medical Group is contractually responsible for provision of behavioral health services and activity and if the health plan has delegated this responsibility. The UMC will meet quarterly if required by a contracted health plan but at least semi-annually.

If the committee meets quarterly, urgent issues will be addressed separately by the designated practitioner and/or subcommittee.

5.8 Special Subcommittees

The purpose of subcommittees/task forces is to assist the UMC in activities, which include but are not limited to the following:

- Recommend new Specialists to the membership of the Credentialing/Re-credentialing Committee
- Develop criteria for outcome and focus studies
- Develop clinical pathways to be used as a reference tool by the practitioners
- Assist in the process for evaluating the inclusion of new medical technologies and specified intervals, including medical and behavioral health procedures, pharmaceuticals and devices
- Implement standards for timelines of medical management decision-making based on clinical urgency and health plan requirements
- Oversee the evaluation and implementation of actions to improve performance (as appropriate) for consistently meeting these standards
- Monitor and evaluate the Utilization Management Program with implementation of Quality Improvement activities
- Evaluate medical appropriateness of denials, the clarity of the documentation and communication of the reasons for denial

5.9 Structure of Sub-Committees

The sub-committee and/or task force are interdisciplinary. Membership includes representation from the following disciplines and areas: Medical Directors, Physician(s), Inter-departmental heads, and clinical staff. The sub-committee and/or taskforce will conduct meetings on an “as needed” basis. Determinations and recommendations from these sub-committees will be presented to the Utilization Management Committee for approval. All policies and procedures are reviewed and approved by the Utilization Management Committee and/or Quality Improvement Committee (QIC) as appropriate.

Improvement interventions, as a result of performance measurement activities will be disseminated to all appropriate parties throughout the Medical Group/IPA structure via IPA Newsletters, Office Manager forums, or other selected modalities.

6. PROGRAM STRUCTURE

The Director of Medical Management along with the UM/CM Managers have the day-to-day responsibility for the implementation of UMP under the direction of the Medical Director. The Medical Director is responsible for providing leadership, policy direction, clinical support and oversight of the UM activities. This includes monitoring and oversight of the UMP activities and services and ensuring that fiscal and administrative management decisions do not compromise the quality of care provided to patients

To achieve an effective UMP, dedicated resources are required to provide a number of specific functions: These functions include, but are not limited to:

- Referrals Management
- Verify eligibility and benefits of members
- Monitor utilization patterns and trends and reporting
- Document denials based on medical necessity, utilizing established criteria or guidelines
- Notify decisions to members, providers, and vendors, which may include denials, modifications, deferrals, approvals or terminations.

The following clinically experienced, licensed personnel and non–licensed staff support the UMP:

CVBC Medical Director
Medical Group/IPA Medical Director
Medical Group/IPA Physicians
UMC Chairperson
Director Medical Management
UM/CM Manager
Health Plan UM staff
Licensed Nurses with expertise in Authorizations, Case Management and Benefits
Clerical support staff

The following describes the roles and responsibilities that support the UM Program structure:

6.1 Medical Director

The CVBC Medical Director is a physician with a current license to practice without restriction in the State of California and is available full time. He/She works collaboratively with the Medical Group/IPA Medical Director and is responsible for the management and oversight of all clinical activities and decision-making within the CMS Utilization Management Department. The CVBC Medical Director reports directly to the CVBC Chief Executive Officer and all activities are reported to the Medical Group/IPA Board of Directors.

Responsibilities include active involvement in the development, implementation, and oversight of the activities of the Utilization Management Program.

6.2 UM Committee Chairperson

The Medical Group/IPA UMC Chairperson's responsibilities include, but are not limited to, the following:

- Chair all Utilization Management committee meetings or designate a substitute in his/her absence
- Participate in the determination of the UMC schedule, oversee the documentation of UMC minutes and other documentation associated with the UMC
- Oversee the development and implementation of policies and procedures associated with the referral process
- Oversee the training and education of all primary care physicians within the group regarding UM policies and procedures and regulatory requirements as well as the training and education of new UMC members
- Communicate to the Board of Directors any issues that impact the clinical operations of the UMC

6.3 Physicians

The physicians have an un-restricted license to practice in California. They act as advisors to the UMC. They are responsible for the following:

- Review of UM cases and reports
- Provide medical expertise on standards of care
- Provide medical opinion and guidelines to UMC for review and approval of criteria used for medical decision-making

6.4 Director Medical Management

The Director of Medical Management is a licensed health care professional, who is responsible for end-to-end design and delivery of the clinical programs. The Director of Medical management provides general oversight of the UM program, helps identify health priorities and quality focus, analysis of data and trends as well as the delivery and governance of the UM/CM programs. Responsibility include direct supervision of UM/CM managers and staff, the day-to-day operations and functions of the UM Department, participates in staff training, monitors for consistent application of UM criteria, monitors documentation for accuracy, and is available to UM staff on site or by telephone. He/She is responsible for ensuring that the UMP is implemented and monitors the effectiveness of the UMP. The Director over sees the integrity of the UM policies, and is also responsible for

ensuring the integration of care, implementation of best practices in care delivery solutions. The Director help solution process improvements along with the Medical Director and Chief Operations Officer.

6.5 UM/CM Manager

The UM/CM Manager, a licensed health care professional reports to the Director of Medical Management. He/She is responsible for the direct supervision of UM staff and the day-to-day functions of the UM Department, participates in staff training, monitors for consistent supplication of UM criteria, monitors documentation for accuracy, and is available to UM staff by on site or by telephone. He/She is responsible for ensuring that the UMP is implemented and monitors the effectiveness of the UMP. The UM/CM Manager makes recommendations for process improvements to the Medical Director and Chief Operations Officer.

6.6 UM Staff

The licensed clinical staff are dedicated to the UM Department for the day-to-day functions and implementation of the UMP. The CVBC Medical

Director is available full-time for oversight of clinical decision-making of the clinical staff.

The non-clinical staff are responsible for the following activities that support the UMP:

- Work in coordination with the CVBC nurses, Medical Director and Care Coordination to ensure compliance with policies and procedures for proper completion of referral requests
- Accurately and promptly enters referral requests from network physicians into the computer system within 2 days of receipt for non-urgent requests and 4 hours for urgent requests
- Verify patient eligibility for referral requests
- Prints and mails finalized referrals daily
- Identify and refer CCS cases to Nurse Case Manager
- Respond to incoming calls timely
- Process referral requests within prescribed scope of authorization as defined by policy
- Coordinate care and referrals to members for Long Term Support Services

7. IMPLEMENTATION OF UMP ACTIVITIES

The UMP is a comprehensive, systematic, and ongoing program. It incorporates prospective, concurrent, retrospective review and case management to meet program objectives. The clinical professionals review inpatient hospitalizations, outpatient surgeries, outpatient services and procedures, rehabilitative services, home care, ancillary services, pharmacy services, and specialty physician services, based on the Health Plan's delegation. The program monitors continuity of care as well as strives to identify over/under utilization. The Medical Director has access to resources and nationally recognized criteria for determination of medical appropriateness.

7 Authorization Request Process

Requests for services are reviewed in accordance with approved guidelines adopted by health plans and the UMC. Decisions are made according to medical necessity criteria and the patients benefit structure. The Medical Director and physician consultant from appropriate specialties of medicine and surgery are available and used as needed for referral reviews and medical necessity decision-making. Medical decisions, including sub-delegated entities and rendering providers if applicable, are not unduly influenced by fiscal and administrative management. UM decisions are based on appropriateness of care and service and existence of coverage. No provider, employee, nor participant involved in

Utilization related decisions shall not receive compensation for denial of service or care. Incentives are not offered to encourage underutilization of services.

The types of review requests include the following:

- Prior Authorization Review
- Concurrent Review
- Emergent/Urgent Review
- Expedited Review
- Second Opinion Review
- External Independent Review/Independent Medical Review
- Reconsideration/Appeal Review
- Retrospective Review

Review criteria used for decision-making are available for disclosure to the physicians, members, their representatives, and the public upon request. Notification of how to obtain a copy of the criteria used to make referral determinations as well as how to contact the physician reviewer is made to physicians through the provider newsletter, the provider manual and on the website. A copy of the decision making criteria can be obtained by calling the Customer Service Department at (888) 445-0062.

The Review and Approval Process includes the following:

- All decisions are made by licensed clinical professionals and any decision to deny a request is reviewed by the CVBC Medical Director. The Medical Group/IPA Medical Director who is a licensed clinical professional may make a decision to deny a request as an alternate to the CVBC Medical Director in the event that the CVBC Medical Director is not available.
- When necessary, Specialty Physicians, including psychiatrists and psychologists, who are trained and/or Board certified in their specialty are utilized as consultants for expertise in decision making. A list of these physician consultants (reviewers) is available to the Health Plans and providers upon request.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence which is updated regularly and consistently applied. Each clinical staff member has access to an electronic form of MCG Guidelines. Policy UM 1002 Clinical Criteria for Decision Making outlines how criteria are developed and selected and how it is reviewed, updated and modified. The organization uses established criteria as outlined in the policy and does not develop its own.
  Information used to guide UM determinations include patient records and conversations with appropriate physicians as

appropriate.

- The physician reviewer uses Medicare guidelines when making decisions for Medicare members
- Reasons for denial decisions are clearly documented.
- There is an appeals procedure for both providers and members.
- Decisions are made in a timely manner, in accordance with State, Federal, and Health Plan regulations.
- UM decisions are made independent of financial incentives and obligations.
- For Medicare Deeming, the Medical Group/IPA complies with national coverage decisions, general Medicare coverage guidelines and written coverage decisions of local Medicare contractors. The organization adopts and implements written policies and procedures that allow a member's representative to facilitate care or treatment decisions when the member is unable to do so. (new NCQA)

7.1 Sensitive Services

State and federal regulations require that certain services be available without a need for prior authorization. Exceptions to prior authorizations requirements are:

- Emergency services (medical screening and stabilization)
- Preventive health services, including immunizations
- Family Planning Services including outpatient abortions through any family planning provider
- Basic prenatal care, including OB/GYN in-network referrals and consultants
- Sensitive and confidential services and treatment, including but not limited to services relating to sexual assault, pregnancy and pregnancy related services, family planning, abortion/pregnancy termination, sexually transmitted diseases, drug and alcohol abuse, HIV testing and treatment, and outpatient mental health consulting and treatment
- The right to access Sexually Transmitted Diseases (STDs) services both within and outside the provider network. The Plan will provide follow-up care
- Access to confidential HIV testing and counseling services either from an in-network provider or from the local health department and family planning providers
- Minors, 12 years and older, do not require parental consent to receive confidential services, such as family planning, diagnosis and treatment of STDs, abortion, medical care related to sexual assault or rape, and emergency medical services (if parent/guardian is unavailable)
- Annual well woman care;
- Adults may self-refer with out Prior Auth.
- Confidentiality must be protected regardless of method of requested communication; this may include information sent to an alternative

location. Provider Organization will not inform parents or legal guardians of a minor's Sensitive Services care and information without minor's permission, except as Allowed by law.

7.2 Referral Timelines

Referrals are processed in accordance with state, federal, and health plan regulations. See Section 15, Exhibit A for timelines by lines of business.

7.3 Prospective Review

Prospective review is a component of referral management. It allows for benefit and eligibility determination, evaluation of proposed treatment, determination of medical necessity of the treatment and referrals, level of care assessment, assignment of the length of stay for in-patient admissions, and appropriate utilization of providers or facility prior to the delivery of service for optimal patient outcomes. These requests are processed on a routine basis, unless otherwise indicated.

Expedited (urgent, stat, fast) determinations may be requested telephonically or in writing and are reviewed for appropriateness of the request. Please refer to Exhibit A for timelines in processing these requests.

The activities of Prospective Review include but are not limited to:

- Pre-certify inpatient admissions
- Prior authorization of referrals for outpatient services
- Identify potential members for Case Management
- Identify potential quality of care issues, using specified quality indicators and nursing judgment and submit to the appropriate QM personnel
- Identify potential fraudulent or abusive practices and report to the appropriate Medical Group/IPA UMC, QI Committee, and Credentialing Committee
- Ensure appropriate diagnosis, procedure, and code usage
- Determine disposition of referral (approve, deny, modify, defer and terminate)
- Obtain pertinent patient history and records for decision making
- Conversations with appropriate physicians as necessary for decision making

7.4 Direct Referrals

Direct referrals do not require prior authorization or review from the Utilization Management department prior to services being rendered. The types of referrals on a direct referral form are determined by the UMC and

allow members to access certain services in a timely manner. Any services/procedures not on Direct Referral Forms require prior authorization. The UMC reviews a direct referral claims paid report on a quarterly basis to monitor over/under utilization by Primary Care Physicians (PCPs).

7.5 Concurrent Review

Concurrent review is the process of reviewing inpatient health care services at the time they are being rendered to ensure medical necessity

of services, continuation and duration of care, appropriate level of care, timely discharge planning, and concurrent identification of quality of care issues. Concurrent review is performed on all admitted members in the following facilities:

- Acute care hospitals, in and out of network
- Skilled Nursing Facilities
- Acute Rehabilitation facilities or units
- Mental health facilities or units (when it's the responsibility of the Medical Group/IPA)

The activities of Concurrent Review include but are not limited to:

- Determine medical necessity based on established criteria and guidelines
- Determine lengths of stay
- Determine appropriate level, intensity of service, and setting of care
- Ensure access to ancillary services
- Identify potential quality of care issues using specified quality indicators and nursing judgment and referring to the QI Department to investigate and discuss with the Medical Director
- Identify potential fraudulent or abusive practices and reporting to the appropriate Medical Group/IPA UMC, QI Committee, and Credentialing Committee
- Change or determine the level of case management when appropriate
- Initiate timely discharge planning activities

Review for medical necessity and level of care may be conducted onsite or telephonically by licensed nurses. On-site nurses will comply with all of the facility's regulations for conduct and concurrent review.

7.6 Retrospective Review

Retrospective review is the process of reviewing requests or claims for services, after the services have been rendered. Types of requests may include hospitalizations, out of area (OOA) or out of network (OON) admissions or services, home health services, DME, consultations, and procedures that have not been submitted through the prior authorization process, are part of an appeal or reconsideration, or the claim does not match the authorized services. Retrospective review may involve the clinical review process for claims and related records and is based on medical necessity and appropriateness of care using guidelines as defined in the prospective referral review process and benefit structure. The Medical Group/IPA may utilize the Retrospective Review process as a monitoring modality for utilization tracking and trending.

The activities of Retrospective Review include but are not limited to:

- Provide review for medical necessity and appropriateness of services
- Identify potential quality of care issues using specified quality indicators and nursing judgment and referring to the QI Department to investigate and discuss with the Medical Director
- Evaluate utilization issues not addressed or identified in the prospective and concurrent review process
- Review linkages and coordinate care for results of facilitation or opportunities for improvement
- Conduct review for unanticipated admission or services when a prospective review was not performed at the time of request. Make decision and notification within thirty (30) calendar days from request.

7.7 Deferral Process

A referral may be deferred when there is insufficient information, either clinical or administrative, to make a decision. Once the information needed is determined, the referral is deferred until the requesting provider submits the additional information or the timelines have been reached. Only a physician can make the determination to approve, modify, or deny a deferred request. Written notification is given to both the member and requesting provider and includes the information needed. The timelines for deferred requests as outlined in Exhibit A are compliant with all health plans and regulatory requirements.

The reasons for deferral include, but are not limited to:

1. TAR or Health Plan tracking number
2. Additional information
3. Benefit or eligibility determination
4. Second opinion needed prior to authorization
5. Clarification of a request

7.8 Referral Modification or Denial Process

Only a licensed and appropriately trained physician can make a determination to modify or deny a service request. All denials or modifications of services will be communicated to the provider and member in writing. The communication will contain all information required by applicable regulation including, but not limited to the reasons, medical criteria, benefit exclusions and/or eligibility status, and the appropriate appeals process, in writing to the member and requesting physician/provider/practitioner.

7.9 Notification of Referral Decisions

Standard notification letters are utilized for all denial decisions and are approved by the Health Plan and meet the accrediting and regulatory requirements in both content and format. All denial notifications include health plan and line of business specific appeals information.

7.10 Second Opinion Process

The second opinion process provides members and providers with the ability to validate the need for specific procedures. The use of screening criteria will be employed in addition to securing a second physician consult, when necessary. Second opinions will be rendered by an appropriately qualified health care professional identified as a primary care physician or a specialist who is acting within his or her scope of practice, and who possesses clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

7.11 Provider Reconsideration

A provider requesting a second review of a referral request decision may write or call to supply additional information for discussion with the Medical Director of the group. This early process is referred to as reconsideration. This process usually occurs prior to issuance of the denial notification to the member.

7.12 External Review and Independent Medical Review

Any member may request an Independent Medical Review (IMR) in accordance with contractual and regulatory requirements to obtain an impartial review of a denial decision concerning the medical necessity of a proposed treatment, experimental or investigational therapies for a life-threatening or seriously debilitating disease or condition, or denied claims for out-of-plan emergency or urgent medical services.

7.13 Review of Requests for Behavioral Health Services

Behavioral health/mental health services are carved out, delegated to the Medical Group/IPA, or managed directly by the health plan. Requests for these services are managed in compliance with contractual and legislative requirements for review of requests for services.

When the Medical Group/IPA is delegated for behavioral health/mental health services, the Medical Group/IPA shall have a contract with a designated behavioral health practitioner who has substantial involvement in the implementation of behavioral health aspects of the UM program.

Staff who makes clinical decisions is supervised by a licensed master's level practitioner with 5 years of post-master's clinical experience.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a licensed clinician, acting within their scope of practice, with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist, if delegated for behavioral health. When these services are delegated, the following process is implemented:

- All requests for behavioral services are generated by the treating physician
- Behavioral health requests are input into the computer system to generate an authorization number and make information available for tracking and reporting
- The authorization number is forwarded to the patient and the behavioral health specialist
- The behavioral health provider evaluates the member and develops a treatment plan
- The treatment plan is reviewed by the medical director to ensure compliance with the health plan benefit structure
- If the treatment type and duration is compliant with the benefit structure, the behavioral health specialist is given an authorization for the services as requested
- Denials will only be made when services requested are not a covered benefit
- The denial decision will be made by a licensed physician in compliance with all contractual and regulatory requirements for denials and notification

When behavioral health/mental health services are not delegated, the following procedure will be followed:

- All requests will be denied by the medical director as not a covered benefit through the medical group/IPA
- Member will be notified of the denial and given information on the carved out providers or vendor of the services in compliance with health plan contractual requirements

7.14 Pharmaceutical Management

Management of the Pharmacy benefits is not delegated. Periodically, the health plans provide pharmacy reports. These reports are reviewed and discussed at UMC meetings. Corrective action plans are recommended for adverse trends as needed.

8. UM TRACKING, TRENDING, AND REPORTING

The UM Department facilitates the delivery of appropriate care and monitors the impact of the care to detect and correct potential under-and over-utilization of services. Data is collected and analyzed by line of business to determine that appropriate and timely care is being provided. When identified, under- and over-utilization of services is addressed through interventions including, but not limited to physician education, implementation of new and/or additional care guidelines, intensive review of physician practice patterns, and/or modification of the network. The UM department utilizes an electronic documentation system and scanning system for all referrals and documentation received. The UM department complies with all health plan and regulatory reporting requirements and timelines.

The following data elements are some examples of the data that are collected, reviewed, and, as appropriate, actions are taken to make improvements. UM Data is reported to the Health Plans in accordance with our delegation agreements, with UM Committees, and/or other departments, on monthly or quarterly basis.

- Bed day utilization reports
- Denials
- Turnaround times
- ER Utilization
- Daily management reports

These reports are used to detect and monitor over and under utilization by isolating factors affecting utilization. Variances in reports quarter over quarter may indicate changes in utilization patterns creating over and under utilization that would need to be addressed by the committee.

The performance standards used to evaluate over and under utilization are based on benchmarks of all groups managed by CVBC. At least annually a quantitative analysis is performed with the data collected against the established thresholds. The data monitored is critical to developing effective interventions and must include practitioners and other personnel who understand processes of care the potential barrier to improvement.

9. COMMUNICATION

The UM Department staff is available via a toll-free number at least 8 hours a day during normal business days for inbound and outbound calls regarding UM issues in compliance with contractual and regulatory requirements. The hospitalists and nurse UM staff are available to receive inbound communication after normal business hours for inbound call regarding UM issues. The UM and Member Services Department staff are responsible for outbound communication regarding inquiries about UM during normal business hours, unless otherwise agreed upon The UM and Member Services Department staff identifies themselves by name, title and our organization name when initiating or returning calls regarding UM issues.

10. CASE MANAGEMENT PROGRAM

The Case Management Program is an ongoing collaborative process that strives to assure the delivery of health care services in a responsible, cost-effective manner. Case Management is a distinct and unique program that identifies covered persons with specific health care needs in order to facilitate the development and implementation of a plan to efficiently use health care resources to achieve optimum member outcome. Case Management activities are complimentary, not duplicative of Utilization Management activities. It is the responsibility of the primary care physician to provide basic case management services.

10.1 Staffing

Case Managers are licensed Registered Nurses/ or Licensed Social Workers and have caseloads which are variable depending on the complexity of the cases managed.

10.2 Responsibilities

- Case identification and screening
- Follow members across the continuum of health care from outpatient to inpatient settings
- Develop comprehensive goals
- Develop, implement, and modify an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the member and/or their family
- Analyze all data for formulating appropriate recommendations
- Coordinate services for members for appropriate levels of care and resources
- Assess member's support system
- Document all findings
- Monitor, reassess, and modify the plan of care to ensure quality, timeliness, and effectiveness of services
- Assess the outcomes of case management and present findings to the Primary Care Physicians and/or providers

10.3 Case Management Process

- Referral/Case Identification
- Intake
- Assessment
- Risk stratification
- Care Plan development
- Coordinate/Monitor services
- Reassess and modify Care Plan and Services
- Terminate/Close case

11. INTERFACE WITH QUALITY IMPROVEMENT

The UM Department works closely with the QI Department to enhance the ability to identify quality of care issues, access issues, referral turnaround times, case management referrals, Emergency utilization, use of ancillary services, as well as appeals and grievances.

11.1 Appeals and Grievances

The right to appeal a UM review decision is available to the members, their representative, or physician, if they disagree with the review or coverage determination. The process for filing an appeal is incorporated into the notification letter sent to the member when there is an adverse decision.

The appeals process is in place to be used in cases when the group is delegated for the appeal and grievance function. When delegated, the QI department is responsible for intake, investigation, and resolution of the appeal.

In cases where the Medical Group/IPA is not delegated for the appeals and grievance process, the QI department is notified by the Health Plan and obtains all pertinent information as it relates to the appeal or grievance and responds back to the Health Plan with information. All information is confidential. The QI department tracks and trends all appeals and grievances for any quality of care concerns and reports to the UM, Credentialing, and QI committees.

11.2 Health Education

The UM Department works collaboratively with the Health Education Department to ensure that members have access to educational materials and services.

12. CONFIDENTIALITY

All personally identifiable member related information (health care or financial), whether written, oral, or electronic communication is maintained in strict confidentiality in accordance with policies and procedures and applicable laws and regulations. The data is maintained as private, secure, and confidential and is shared with only those who have a need to know such information in order to perform health care services, pay for such services, or perform administrative activities on behalf of the Medical Group/IPA.

Any request to release member specific confidential information requires member consent prior to release to any party, unless there is a business need. Behavioral health care records require member consent, patient waiver of notification, or written notification as required by state law. The released information will include only that portion specific to the request or which is legally required to be disclosed. A record will be maintained for twelve (12) months which identifies the party that requested the information, the purpose of the request, the party to whom the information was released, the date of release and what exact, specific information was released.

13. ETHICS, MEMBER RIGHTS AND RESPONSIBILITIES

Member's Rights and Responsibilities are included in New Member materials provided by the member's healthplan. These materials are distributed to all new members in their Evidence of Coverage.

14. GLOSSARY

Appeal – A special kind of grievance. It is a written or oral expression from a member or provider for reconsideration of a determination of a provider request resulting in a denial/ modification/ delay by a health plan with a goal of finding a mutually acceptable solution or to resolve a disputed question of fact. Examples of actions which may be appealed may include, but are not limited to, the following:

- The denial, modification, delay or limited authorization of a provider requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service; or
- The failure to furnish or arrange for a service or provide payment for a service in a timely manner.

    - **Standard appeal** – A formal **appeal** process whereby a member or provider exercises his or her right to contest and request a reversal of a decision to deny or partially deny a benefit, service or claim. A final disposition on a standard appeal must be made and communicated back to the member and provider within 30 calendar days.

    - **Expedited appeal** - A formal **appeal** process whereby the **appeal** and the final determination of that **appeal** is made and processed back to the member and provider within a timeframe not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. **Appeals** are expedited when waiting for a standard decision may be detrimental to the enrollee's life or health including but not limited to severe pain, potential loss of life, limb or major bodily function. The expedited **appeal** process does not apply to a denial of payment for services already received.

Authorization – A process of review to determine if request for service or payment should be authorized.

Case Management - (see also Utilization Management) – A patient-centered multi-disciplinary process of identifying members with specific health care needs in order to assess plan, coordinate, and facilitate the development and implementation of a care plan to efficiently use health care resources to achieve optimum member outcomes.

Concurrent Review – A contemporaneous review of medical necessity, quality and appropriateness of care while the service is being rendered. In a medical care facility, would also include reviewing for appropriateness of level of care, length of stay, services being provided, and discharge planning and coordination care after member leaves the medical facility, to achieve quality and cost effective outcomes.

Criteria – Standard, evidenced based and consensus driven screening guidelines utilized to determine medical appropriateness of care. These guidelines are not absolute, but are used based on the individual medical needs of the member and in accordance with the capability of the health care delivery system.

Deferral – Any referral request requiring additional information to process.

Delegation – A formal process by which an organization gives another organization or entity the authority to perform certain functions on its behalf. The authority may be delegated, but the responsibility for assuring that the function is performed appropriately cannot be delegated.

Denial/ Modification – Utilization Review decision to not authorize, modify, or delay a request for service, treatment, visits, inpatient days, medical supplies, etc. and/ or withholding payment for services or medical supplies based on review of established standards and/ or criteria for appropriateness, medical appropriateness, or benefit coverage.

Discharge Planning – The comprehensive multi-disciplinary evaluation of a member's health needs to arrange for appropriate care/ transition of the patient to the next phase of care, following discharge from an institutional clinical care setting.

Grievance – A written or oral expression of dissatisfaction regarding the plan and/ or provider, including quality of care concerns, and shall include a complaint, dispute, requests for reconsideration or **appeal**, made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Medical Necessity – All covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

When determining the medical necessity of health care services for a Medi-Cal beneficiary under age 21, the term “medical necessity” is expanded to include all services necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by a health care practitioner operating within the scope of his or her practice as long as the services are medical in nature and are not requested solely for the convenience of the beneficiary, family, physician, or another provider of services. These services must be provided to beneficiaries under the age of 21 regardless of whether the service would otherwise be available to beneficiaries over the age of 21 under the Medi-Cal program.

Peer Review – A review conducted by professional peers to determine compliance with standards of acceptable practice and care.

Potential Quality Issue (PQI) – A deviation or suspected deviation from expected provider performance, clinical care or outcome of care which cannot be determined to be justified without additional review. Such issues must be referred to Quality Improvement personnel for incorporation into the QI review process. Not all PQIs will be found to be quality of care issue or problem.

Prior Authorization – A review process to determine if designated requested services are appropriate and necessary for a particular patient and if those services are to be approved for payment before the service is rendered.

Prospective Review/ Prior Authorization – The process of reviewing proposed outpatient and inpatient services prior to the performance of services, to evaluate covered benefits, the appropriateness and necessity of medical care for a particular patient/ condition, the appropriateness of the location and provider(s) of services, and the proposed length of stay at an inpatient facility.

Provider – A person, group, or legal entity that renders health care services; may include physicians, therapists, hospitals, groups and allied health care workers, etc.

Quality Management – A comprehensive, ongoing and systematic process initiated to monitor, evaluate and improve the quality and appropriateness of the health care delivery system.

Reconsideration – A potential appeal to Medical Group/IPA of an initial review determination issued by medical group or the Medical Group/IPA. See appeal.

Referral – A written request for authorization of services. Can also be a request for coordination of services to non-health plan managed related services and activities.

Rendered – A service actually performed by a provider.

Retrospective Review – A review process to determine medical necessity, appropriateness of and site of service, and quality care on a case-by-case or aggregated basis after service and/ or care has been rendered.

Utilization Management - (see also Case Management) – A formal, prospective, concurrent or retrospective critical examination of appropriate use of segments of the health care systems and services, such as hospitalization, clinics, provider services, emergency department, skilled nursing facilities, home care, medical equipment and supplies. Aggregated data, claims/ encounter data, clinical criteria as well as medical records may be reviewed to determine the appropriateness of admission or procedures, length of stays, level of care, ancillary services and quality of care.

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request	Within 5 working days of receipt of all information reasonably necessary to render a decision	Practitioner: Within 24 hours of the decision Documentation and proof successful transmission of these processes is required (e.g.; fax transmission receipts; call log including phone number, time of call, person who placed the call). Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer • Additional examination or tests to be performed (AKA: Deferral)	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request • The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered		
	Additional information received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	Additional information incomplete or not received • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial	Practitioner: Within 24 hours of making the decision Member: None Specified If additional information is received by the 12 calendar date, the delegate will not have an additional 2 business days to send the notice of the decision. • The notification shall never exceed 14 calendar days.	service Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request	Within 72 hours of receipt of the request **For Health Net and Cal Optima Medi-Cal Members:** Health Net utilizes APL 17-006 for determining turn-around times for urgent requests. • The decision, member and provider notice all must be completed within 72 hours of receipt of the request.	Practitioner: Within 24 hours of making the decision Documentation and proof successful transmission of these processes is required (e.g.; fax transmission receipts; call log including phone number, time of call, person who placed the call). Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.	**Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered • Note: The time limit may be extended by up to 14 calendar		

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
• Additional clinical information required	days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest **Additional information received** • If requested information is received, decision must be made within 1 working day of receipt of information. **Additional information incomplete or not received** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	Practitioner: Within 24 hours of making the decision Member: None specified Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of Member's medical condition **NOTE:** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	CA H&SC 1367.01 (h)(2)		
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) **OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may choose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 24 hours of receipt of the request	Practitioner: Within 24 hours of receipt of the request (for approvals and denials) Member: Within 24 hours of receipt of the request (for approval decisions)	Member & Practitioner: Within 24 hours of receipt of the request **Note:** If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt or request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request
Post-Service - Extension Needed • Additional clinical information required	**Additional clinical information required (AKA: deferral)** • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request **Additional information received** • If requested information is received, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information **Additional information incomplete or not received** • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the	Member & Practitioner: None specified Member & Practitioner: None Required	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	information		
Hospice - Inpatient Care	Within 24 hours of receipt of request	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision
Prescription Drugs [Welfare & Institutions Code 14185] **NOTE:** Applies to Injectables & Infusions that require prior authorization.	▪ **All requests:** Within 24 hours or one business day of a request for prior authorization made by telephone or other telecommunication device [W&I code 14185]	Practitioner: ▪ **All requests:** A response within 24 hours or one business day to a request for prior authorization made by telephone or other telecommunication devise. [W&I code 14185] **NOTE**: W&I code does not address member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.	**NOTE:** W&I Code does not address written notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for written notification timeframes.

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

REFERRAL TIMELINES – EXHIBIT A

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. **Note:** If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	**Additional clinical information required:** Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. **Note:** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after receipt of information.	*Additional information received or incomplete* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	*Additional information received or incomplete* Within 48 hours after receipt of information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
	Additional information not received: If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. **Note:** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after the deadline for extension has ended.	*Additional information not received* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials). Member: Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions). Document date and time of oral notifications.	*Additional information not received* Within 48 hours after the timeframe given to the practitioner & member to supply the information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. **Exceptions:** • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to *Urgent Pre-service* category. • If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to *Non –urgent Pre-service* category.	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.

REFERRAL TIMELINES – EXHIBIT A

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Standing Referrals to Specialists / Specialty Care Centers - All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. **NOTE:** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer: Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	*Require consultation by an Expert Reviewer:* Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 2 business days of making the decision.

REFERRAL TIMELINES – EXHIBIT A

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	*Additional information received or incomplete* Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	*Additional information received or incomplete* Within 15 calendar days of receipt of information.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	*Additional information not received* Practitioner: Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). Member: Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	*Additional information not received* Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.	*Require consultation by an Expert Reviewer:* Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 15 calendar days from the date of the delay notice.
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity) 2. Non-Urgent (e.g., post-service pend or denial notifications)	*LAP Services Not Delegated:* All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request 2. Request forwarded within two (2) business days of member's request		*LAP Services Delegated/Health Plan:* All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.

REFERRAL TIMELINES – EXHIBIT A

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Prescription Drugs CA Health & Safety Code section 1367.241 (CA SB 282; 2015-2016) **Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.*	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS) and Cal Medi-Connect

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Electronic or written notice to Approve, Deny or Modify within 5 working days of receipt of all information reasonably necessary and requested to render a decision but no longer than 14 calendar days after receipt of request.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers. With an extension, the delegate makes decisions within 17 calendar days of receipt of the request.	▪ Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. ***Extension Notice:*** ▪ Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.
Expedited Initial Organization Determination - If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function and if an extension not to exceed fourteen additional calendar days if such outstanding information is reasonably expected to be received within fourteen calendar days or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies:	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the

Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS)and Cal Medi-Connect

Type of Request	Decision	Notification Timeframes
	▪ Automatically transfer the request to the standard timeframe. ▪ The 14 day period begins with the day the request was received for an expedited determination.	member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination - If No Extension Requested or Needed (See footnote)[1]	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ **Approvals** – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request. – Use NDMC template for written notification of a denial decision.

For urgent and nonurgent preservice decisions resulting in approval, denial or modification, the Delegate gives telephonic or electronic notification of the decision to requesting provider within 24 hours of the decision. Documentation and proof of successful transmission of these processes is required (e.g.; fax transmission receipts; call log including phone number, time of call, person who placed the call)

For urgent and nonurgent preservice decisions resulting in denial, delay, or modification, the Delegate gives written notification of the decision to practitioners and members within 2 business days of the decision.
• If additional information is received by the 12 calendar date, the delegate will not have an additional 2 business days to send the notice of the decision.
• The notification shall never exceed 14 calendar days.

For post service decisions, the delegate gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)
and Cal Medi-Connect

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	▪ Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. ***Extension Notice:*** ▪ Give notice **in writing,** within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ **Approvals** – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider no later than upon expiration of the extension. ▪ **Denials** – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)
and Cal Medi-Connect

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within 2 calendar days of admission to a hospital inpatient setting. 2) not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital. ▪ NOTE: Follow up copy of IM is not required: ▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge. ▪ When member is being transferred from inpatient to inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.	Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO. The DND must include: ▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. ▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization. ▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. ▪ Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case.

Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)
and Cal Medi-Connect

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
			▪ Any other information required by CMS.

Type of Request	Decision	Notice of Medicare Non-Coverage (NOMNC) Notification	Detailed Explanation of Non-Coverage (DENC) Notification
Termination of Provider Services: ▪ **Skilled Nursing Facility (SNF)** ▪ **Home Health Agency (HHA)** ▪ **Comprehensive Outpatient Rehabilitation Facility (CORF)** NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services **OR** ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative ▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. **Note**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: ▪ The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

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Utilization Management Timeliness Standards for
CMC Centers for Medicare and Medicaid Services
(CMS) and Cal Medi-Connect

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	Request under the CMC Member's Medicare Benefit: As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Request under the CMC Member's Medicare Benefit Within 14 calendar days after receipt of request. ▪ Use the Notice of Integrated Denial Notice (IDN) template for written notification of denial decision.
	Request under the CMC Member's Medi-Cal Benefit: Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request.	Request under the CMC Member's Medi-Cal Benefit: Within 14 calendar days after receipt of request ▪ Use the Integrated Denial Notice (IDN) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	Request under the CMC Member's Medicare Benefit: May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny) and there is a need for additional information where such outstanding information is reasonably expected to be received within fourteen (14) calendar days. Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers. Request under the CMC Member's Medi-Cal Benefit:	Request under the CMC Member's Medicare Benefit: ▪ Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. ***Extension Notice:*** • Give notice in writing within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. Note: The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ Must occur no later than expiration of

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Utilization Management Timeliness Standards for CMC
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
	The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the state for the need for additional information and how it is in the Enrollee's interest.	extension. Use NDMC template for written notification of denial decision. Request under the CMC Member's Medi-Cal Benefit: Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
Expedited Initial Organization Determination - If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14 day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination - If No Extension Requested or Needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ **<u>Approvals</u>** – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given.

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Utilization Management Timeliness Standards for CMC
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Notification Timeframes
(See footnote)[1]		–If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **<u>Denials</u>** –When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request. – Use NDMC template for written notification of a denial decision.

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

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Utilization Management Timeliness Standards for CMC
Centers for Medicare and Medicaid Services (CMS)

Type of Request	**Decision**	Notification Timeframes
Expedited Initial Organization Determination - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny) and there is a need for additional information where such outstanding information is reasonably expected to be received within fourteen (14) calendar days. . Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	▪ Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. ***Extension Notice:*** ▪ Give notice **in writing,** within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** ▪ **Approvals** – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider no later than upon expiration of the extension. ▪ **Denials** – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

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Utilization Management Timeliness Standards for CMC
Centers for Medicare and Medicaid Services (CMS)

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
			applicability of the coverage rule or policy to the member's case. ▪ Any other information required by CMS.

Type of Request	Decision	Notice of Medicare Non-Coverage (NOMNC) Notification	Detailed Explanation of Non-Coverage (DENC) Notification
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PHYSICIANS MEDICAL GROUP OF SAN JOSE

UTILIZATION MANAGEMENT PROGRAM

2022

1.0 PURPOSE AND SCOPE

The Utilization Management Program is designed to monitor, evaluate, and manage the quality and cost of healthcare services delivered to all members, assigned to Physicians Medical Group of San Jose (PMGSJ) and managed by EXCEL MSO, LLC (EXCEL). The utilization management structures and process are clearly defined and responsibility is assigned to the appropriate individuals. The written description of the Utilization Management Program outlines the structure and accountability. The program description includes the scope of the program and the processes and information sources used to make determination of benefit coverage and medical appropriateness. The program will ensure that:

1.1 Medical services are medically necessary and are delivered at appropriate levels of care for all product lines – Medicare, Cal MediConnect, Medi-Cal and Commercial. Comprehensive periodic reviews by specialty type and/or service(s) type are conducts to ensure that Medical services are not over- or under-utilized.

1.2 High quality medical care is offered in a timely and authorized in an efficient manner with consideration to the urgency and emergency of the situation, and member's circumstance that may be affected by member's age, complications and comorbidities, treatment progress, psychosocial situation and socioeconomic status, when applicable. UM decisions are made according to most current industry established clinical criteria and turnaround times. Current year Health Plan policy summary of benefits or Evidence of Coverage (EOC) is used to determine coverage and available services.

1.3 Excel MSO, LLC is not delegated to authorize behavioral health services on behalf of the health plans. Excel MSO, LLC does not maintain a network of contracted behavioral health practitioners. Behavior health services are coordinated with the health plans by referring members to the appropriate clinic or provider as indicated by the specific health plan.

1.4 Members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, gender identity, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

1.5 Provision of services are monitored, evaluated, and measured for appropriateness. The Senior Medical Director oversees the implementation of the UM program under the direction of the Chief Medical Officer.

1.6 Medical services are provided by contracted providers and practitioners and authorized by the EXCEL Utilization Management Department, EXCEL Chief Medical Officer/ Sr. Medical Director or the PMGSJ Utilization Management Committee. Out of network providers may be authorized when medically necessary and clinically appropriate. Urgency, availability of contracted providers and continuity of care are some of the instances for consideration of an out-of-network approval.

1.7 Guidelines, standards, and criteria which are set forth by governmental and regulatory agencies, Accreditation bodies, health plans, and PMGSJ Utilization Management Committee, as well as Board of Directors' Approval are adhered to and applied appropriately.

1.8 The medical group will maintain compliance with governmental, regulatory, Accreditation agencies and health plan requirements governing Commercial, including Health Insurance Exchange – Covered California, Medi-Cal, Medicare, and Cal MediConnect populations.

1.9 The medical group will comply with Medicare National Coverage Determinations (NCD), Medicare Managed Care Manual, Local Coverage Determinations (LCD), Medi-Cal Provider Manual, and California Department of Health Care (DHCS), California Children's Services (CCS) – CCS Medical Eligibility Guide.

1.10 The medical group utilizes standardized, evidence based clinical guidelines, such as MCG, Apollo Managed Care, National Comprehensive Cancer Network (NCCN), Health Plan policies and Evidence of Coverage (EOC) and prescribing information to determine medical necessity and appropriateness of healthcare services. When a standardized guideline is not available, a) evidence-based guidelines offered by a specific health plan/LOB or b) internally researched and created PMGSJ specific guidelines may be adopted to determine medical necessity for all appropriate members for whom a service is requested. These are approved by the PMGSJ Utilization Management Committee as well as the Board of Directors.

1.11 The utilization management team of Board-certified physicians, California licensed staff and unlicensed staff carry out the responsibilities designated for their level of expertise.

1.12 Compensation plans for the professional and non-professional staff do not include incentives, directly or indirectly, for review decisions.

1.13 The Utilization Management Program and supporting policies and procedures are reviewed and approved annually by the Utilization Management Committee and Board of Directors.

1.14 The Utilization Management Program will be integrated with the Quality Management Program to ensure continuous quality improvement.

2.0 PROGRAM GOALS

The Utilization Management Program goals are:

2.1 To provide medically necessary health care services that are quality focused, cost efficient and outcome oriented.

2.2 To ensure compliance with the regulations set forth by the regulatory agencies, such as CMS, DHCS, DMHC and the California legislature.

2.3 To ensure compliance with accrediting body standards, such as the National Committee for Quality Assurance (NCQA).

2.4 Meet timeliness of authorization review standards as set regulators for each line of business.

3.0 UTILIZATION MANAGEMENT PROGRAM OBJECTIVES

The Utilization Management Program objectives are designed to meet the goals of the program by ensuring the following:

3.1 Provide access to the most appropriate and cost-efficient health care services.

3.2 Ensure that authorized services are covered under the member's health plan benefits.

3.3 Develop a mechanism to evaluate and determine that services provided are consistent with accepted standards of medical practice.

3.4 Collaborate and cooperate with both internal and external peer review processes.

3.5 Although PMG SJ is not delegated for grievances and appeals, EXCEL cooperates with health plans to ensure thorough and timely investigations and responses to member and provider issues, appeals, or grievances that are associated with utilization management. When appropriate, initiate corrective actions to prevent problematic situations in the future.

3.6 Ensure that services delivered are medically necessary, criteria based and are consistent with the diagnosis and level of care requirements.

3.7 Facilitate communication and develop positive relationships between members, practitioners and health plans by providing education related to appropriate utilization of services.

3.8 Evaluate and monitor health care services provided by tracking and trending data on a regular basis.

3.9 Monitor continuity of care and coordination of care.

3.10 Identify areas of overutilization and underutilization of services by continuous evaluation of the utilization patterns.

3.11 Enhance the delivery of care by recognizing physicians and providers for sound utilization practices and exceptional quality of service.

3.12 Identify "high risk" members and ensure that appropriate care is delivered by accessing available resources.

3.13 Identify members who require complex medical care and ensure that medical and non-medical support services are provided in a timely and appropriate manner through the assignment to Case Management Programs.

3.14 Develop, adopt and implement effective health promotion and disease management programs.

3.15 Analyze and provide utilization management data in the process of evaluating practitioner performance and re-credentialing.

3.16 Identify potential quality of care and service issues and refer to EXCEL Quality Management for investigation and resolution by the health plan.

3.17 Perform UM under health plan delegation. Monitor the inpatient utilization services by continuously maintaining reports such as, acute hospital bed days /1,000, admits/1,000, Acute Admits/1000, Acute average length of stays, and readmission rates. Acute Rehab and Skilled nursing Facility (SNF) bed days /1,000, Admits /1,000 and SNF average length of stays are also monitored.

3.18 Produce and analyze provider utilization and referral pattern reports. Distribute to individual providers for his/her comparative results.

3.19 Monitor the utilization of non-contracted, and tertiary providers and report such findings to the Utilization Management Committee and Credentialing Committee for identifying network needs.

3.20 Develop or adopt and implement clinical practice guidelines to provide high quality and evidence based medical care.

3.21 Continuously monitor, evaluate and improve the Utilization Management Program.

4.0 POLICY

The authorization request determinations are made by the appropriate licensed professionals (MD, DO, LVN, RN), are based only on the appropriateness of care and service. EXCEL and the medical group do not compensate physician or nurse reviewers who conduct utilization review determinations for any denials of coverage or service. There is no financial incentive that is provided to encourage inappropriate denials of service.

All medically necessary decision determinations are based on sound clinical evidence and are criteria based. The criteria are updated, adopted, reviewed and revised, when appropriate, and approved on an annual basis by the Utilization Management Committee and PMGSJ Board of Directors. The EXCEL Chief Medical Officer/Sr. Medical Director, a senior physician with substantial involvement in the implementation of the Utilization Management Program, and, day-to-day operations, will oversee the criteria selection, development, adoption, and application process. Participating practitioners, in appropriate specialty areas, are available to assist in the review, revision and acceptance of criteria when appropriate. The criteria are available to practitioners and members upon request.

Member perception of care (CAHPs) is influenced many factors including the timely approval of authorized services. Recognizing the increased relative weighting of member satisfaction, PMGSJ continues to implement and expand auto-authorization of selected, high-volume/commonly requested/screening services, such as eye exams, colorectal cancer screening, physicial therapy and others. Periodically, analyses are conducted to prevent overutilization of services.

Supporting policies and procedures are in place to provide:

- A mechanism for verifying the accuracy and consistency of application of the criteria by the physician reviewers and non-physician reviewers annually by the inter-rater reliability (IRR) testing.

- The application of the criteria that justifies the appropriateness of services is clearly documented and considers individual patients and the characteristics of the local health care delivery system.

- The process for practitioners and members to follow when requesting copies of criteria is in place.

Urgent care and Emergency services, necessary to screen and stabilize members, are approved, without prior notification or prior authorization, in the event where

a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

Efforts are made to obtain all necessary information (including three (3) documented attempts by telephone and or facsimile), including pertinent clinical information, and documented phone conversations with the treating physicians, as appropriate, for the purpose of reviewing all authorization requests.

Referral/authorization process and associated timeframes for decisions, notification and confirmation are implemented and monitored to comply with the governmental regulatory, The National Committee for Quality Assurance (NCQA), and Industry Collaboration Effort (ICE) standards.

Pre-service authorization, concurrent review and case management decisions and processes are supervised by qualified licensed medical professionals. Physician consultants are utilized to review cases as appropriate from specialty areas of medicine and surgery. UM Director/Manager is responsible for day-to-day supervision, assignments, staff training and provides support for licensed UM staff regarding UM decisions. UM Director/Manager monitors consistent application of UM criteria by clinical staff and monitors accuracy and adequacy of documentation. UM Director/Manager is available to UM staff via telephone, email, and instant messenger.

Only the Chief Medical Officer/Sr. Medical Director or his/her physician designee can make the decision to deny service after conducting a review for medical necessity. Reasons for denial, including criteria used, are clearly documented and available to the member and requesting physician. Notification to the member and requesting physician on a denial of service includes Member's Rights, including information and instructions regarding the process for expedited and non-expedited appeal. Notification to the requesting physician includes information of the Chief Medical Officer/Sr. Medical Director's availability to discuss the case including direct telephone number for peer to peer review. These processes are detailed in the supporting policies and procedures. See PMGSJ UTM030 Denial of Authorization Request.

Utilization management determinations and decision notifications are made in a timely manner consistent with regulatory requirements. The urgency of the situation is always considered to ensure that the request and notification are processed appropriately and according to established timeframes in compliance with regulatory, health plan and ICE standards. The turnaround time for authorization request is monitored on a regular basis and corrective actions are implemented when appropriate. UM reports are monitored daily, weekly, monthly, quarterly and annually and as needed.

The medical group measures member satisfaction and practitioner satisfaction annually, either internally, through health plans or outside vendors, with a focus on the ease of getting requested services approved and obtaining authorizations.

Consumer Assessment of Healthcare Providers and System (CAHPS) surveys are conducted by the health plans annually. Any areas of dissatisfaction are subject to corrective action and re-measurement for achieving and demonstrating performance improvement.

Utilization data is tracked and trended on a regular basis. The data reports are submitted to the Utilization Management Committee, Board of Directors and health plans on a monthly, quarterly, semi-annual and annual basis as required. The analysis of the data focuses on outcomes related to over/under utilization and acceptable rates established for the population being served. The Utilization Management Committee will review and make recommendations for improvement when necessary. A re-measurement process will determine improvements or whether further analysis and actions are required.

Quality of care and quality of service issues are sent to the Quality Management Department for referral to the Health Plan. The Utilization Management Committee and the Quality Management Committee work collaboratively to resolve any cross-related issues or concerns.

The Utilization Management Program will include the effective processing of prospective, concurrent and retrospective review determinations by qualified personnel. The areas of review include, but are not limited to:

- Inpatient hospitalizations (acute hospitals, acute rehabilitation units, long term acute care hospital (LTACH) and skilled nursing facilities)
- Outpatient surgeries (all procedures done outside of the practitioner's office – ambulatory surgery centers or hospital outpatient units)
- Selected outpatient services
- Selected ancillary services
- Home Health services
- Selected physician office services
- Out-of-network services
- Specialist to specialist referrals
- Specialist self-referrals
- Sensitive Services.

Provider and member appeals will be processed according to the medical group and health plan appeals policy and procedure by the Quality Management Department, in accordance with regulatory requirements, such as California AB1455 Provider Dispute Resolution requirements or Centers for Medicare and Medicaid Services. EXCEL MSO is not delegated to make appeal determinations. EXCEL MSO Quality Management Department and UM Department assist in addressing the appeal determinations in a timely manner, as determined by the health plan.

The EXCEL MSO Case Management Program includes basic/ambulatory case management and complex case management, as delegated by health plans. The

program will identify, coordinate, and evaluate services delivered to those members who require intensive management of complex medical care and services. EXCEL MSO case management nurse works closely and in conjunction with the health plan case management and disease management programs. Nurse Case Manager assists members with basic/ambulatory coordination of care tasks, such as tertiary care redirections to in network providers, authorization issues or provider selection or access to care concerns. Complex case management program includes a patient focused care plan that addresses patients' chronic conditions, medications, socioeconomic factors, caregiver support and other potential barriers. Complex Case Management program is based on NCQA standards.

EXCEL MSO Transition of Care (TOC) program includes post hospitalization discharge process of notifying member's primary care physician (PCP). EXCEL MSO staff generate a notification letter to PCP, informing them that member was discharged from the hospital. The notification instructs the PCP to schedule and perform a post hospitalization visit with the member within 7-10 business days post discharge. The instructions also include the need to complete and code medication reconciliation post-discharge (MRP) as required by Centers for Medicare & Medicaid Services (CMS). The PCP notification packet includes CMS Star measures insert that addresses the need for post hospitalization visit with PCP and medication reconciliation quality measure and required coding. EXCEL MSO also faxes a copy of hospital discharge summary if available or latest hospital MD progress note. This information is sent to PCP via facsimile and documented for tracking purposes by EXCEL MSO. Additionally, EXCEL MSO Nurse Case Manager, places an outreach telephone call to PCP to confirm receipt of notification and to remind the office to schedule the member for hospital post discharge appointment and medication reconciliation. Outreach is documented for tracking purposes by EXCEL MSO.

The Utilization Management Program and the supporting policies and procedures will be reviewed, revised as necessary and approved annually, or as needed, by the Utilization Management Committee and the Board of Directors.

The Utilization Management Program will be submitted to the contracted health plans. Other reports will also be submitted to the health plans according to contractual agreements.

Encounter data report will be reported to the health plans on a timely basis as required by each health plan contract.

5.0 ORGANIZATION AND RESPONSIBILITY

The Board of Directors reviews, revises and approves the Utilization Management Program on an annual basis or as needed. Physicians Medical Group of San Jose has a contractual agreement with EXCEL MSO, LLC, a managed services organization to

administer the Utilization Management Program and the supporting policies and procedures.

The EXCEL Chief Medical Officer/ Sr. Medical Director, the designated senior physician, and the EXCEL Chief Executive Officer have the responsibility for overseeing the management and implementation of the Utilization Management Program with a focus on the allocation of resources and staffing, and the overall effectiveness of the Utilization Management Program. The EXCEL Chief Medical Officer/ Sr. Medical Director reports to the Utilization Management Committee and Board of Directors.

EXCEL MSO and their practitioners are ensured independence and impartiality in making referral decisions which will not influence:

- Hiring,
- Compensation,
- Promotion, and
- Any other similar matter

5.1 CHIEF EXECUTIVE OFFICER, EXCEL MSO, LLC.

The Chief Executive Officer of EXCEL MSO, LLC, is responsible for the overall planning development and monitoring of operations in the areas of Utilization Management, Quality Management, Provider Relations and Contracting, Credentialing, Claims and Member Service. The Chief Executive Officer, an executive of EXCEL MSO, reports to the PMGSJ Board of Directors.

5.2 CHIEF MEDICAL OFFICER, EXCEL MSO, LLC.

The Chief Medical Officer of EXCEL MSO, LLC, a physician with active and unrestricted license in California, is responsible for establishing the overall direction of the Utilization Management and Quality Management programs. The Chief Medical Officer, an Executive of EXCEL MSO, reports to the Chief Executive Officer. The Chief Medical Officer participates and presents information to the Utilization Management Committee, Utilization Management Sub-Committee, the Credentialing Committee and PMGSJ Board of Directors.

5.3 SR. MEDICAL DIRECTOR, EXCEL MSO, LLC.

Under the direction of the Chief Medical Officer, the Senior Medical Director of EXCEL MSO, LLC., a physician with active and unrestricted license in California, in conjunction with the UM Director/Manager of Health Services is responsible for the oversight and implementation of the Utilization Management Program that includes the prospective, concurrent and retrospective review process for services provided by the medical group. Other responsibilities include:

- The review process for medical necessity of service requests

- The review of all potential denials of service requests that are not medically appropriate according to established approved criteria
- The day-to-day management of the Utilization Management Department staff.
- Participation and reporting to the Utilization Management Committee.

The Chief Medical Officer/ Sr. Medical Director, or his/her designee is available at all times to the EXCEL Utilization Management Staff and to the medical group practitioners.

5.4 UM DIRECTOR/MANAGER OF HEALTH SERVICES

The UM Director/Manager of Health Services holds an active Advanced Practice nursing license (Nurse Practitioner) issued by California Board of Registered Nursing, and reports directly to the Sr. Medical Director/Chief Medical Officer and is responsible for:

- Overseeing and implementation of the Utilization Management Program
- Overseeing the prior, concurrent and retrospective review process for services provided by the medical group.
- Overseeing ambulatory case management, complex case management and transition of care management processes.
- Formulating and reporting the annual Utilization Management Program, Utilization Management Annual Work Plan and semi-annual reports to contracted health plans.
- Compiling and analyzing utilization management and health plan information to coordinate and improve the health care of the membership.
- Reporting monthly to the UM Committee the prior months utilization data, new policy and procedures (P&P), as well as P&P changes or updates.
- Assisting the Chief Medical Officer/ Sr. Medical Director in the implementation and operation of utilization improvement projects.
- The day-to-day management of the Utilization Management Department's staff.

5.5 EXCEL UTILIZATION MANAGEMENT DEPARTMENT

The Utilization Management Department consists of actively-licensed nurses and non-licensed support staff. The licensed staff are managed by the UM Director/Manager of Health Services. Under the auspices of the EXCEL Chief Medical Officer/ Sr. Medical Director, the nursing staff are responsible for the prospective, concurrent and retrospective review of service requests based upon approval, medical necessity criteria, as well as plan benefits – Evidence of Coverage (EOC). The nursing staff act as support to the Utilization Management Committee and the Chief Medical Officer/Sr. Medical Director.

The non-licensed support staff are managed by a non-licensed Director/Manager. The non-licensed staff are responsible for the confirmation of benefits and

eligibility of the members, data entry, authorization of selected routine requests and other non-review related functions.

5.6 PMGSJ BOARD OF DIRECTORS

The Physicians Medical Group of San Jose Board of Directors has the ultimate responsibility for the oversight and implementation of the Utilization Management Program. The Board of Directors revises, makes recommendations and approves the Utilization Management Program on a yearly basis. In addition, the Board of Directors reviews and approves the Utilization Management Program, annual evaluation, the annual workplan, and Utilization Management quarterly reports. The Board of Directors provides the oversight for the administrative functions conducted by EXCEL that pertain to the medical group.

5.7 UTILIZATION MANAGEMENT COMMITTEE

The Utilization Management Committee is a standing committee of Physicians Medical Group of San Jose, and is accountable to the Board of Directors. The Utilization Management Committee is a standing committee of Physicians Medical Group of San Jose, and is accountable to the Board of Directors. The UM Committee Chairperson is selected by the Board of Directors. The UM Committee members are comprised of seven contracted practitioners selected by the President of PMGSJ and approved by the Board of Directors in accordance with the medical group bylaws. Committee members are appointed for one-year term, but may be re-appointed by the President and the Board.

The Utilization Management Committee has been given authority by the Board of Directors for the implementation and oversight of the UM Program. The Committee analyzes data from utilization activities, reviews and evaluates the outcomes of UM services. The UM Committee is also responsible for formulating, revising, adopting, and approving policies and procedures. The Committee reports to the Board of Directors at least quarterly.

The Utilization Management Committee establishes and maintains solid avenues of communication between the participating practitioners, EXCEL staff, facility providers and health plans. When requested by the Committee, consultants from appropriate specialty areas are available to review cases pertaining to their specialty. The Committee evaluates the quality of care and services, and identifies issues that are forwarded to the Quality Management Committee.

The Utilization Management Committee conducts monthly meeting on the 3rd Wednesday of each month; or meets at least quarterly. To comply with oversight obligations, urgent issues will be addressed by ad-hoc meeting as needed. Representatives from health plans may attend the Utilization Management

Committee meeting with prior arrangements. A confidentiality statement is required, signed and filed in the EXCEL Utilization Management Department.

The Committee maintains meeting minutes that are contemporaneous, dated and signed by the UM Committee Chairperson and include:

- Agenda and supporting documents
- Attendance of the members and non-voting members
- Active discussion, actions and follow-up for utilization issues
- Analysis of utilization data
- Review, revise and approve policies and procedures, programs, reports, criteria and guidelines used in the utilization management process.

Only contracted practitioners on the committee have voting rights. No committee member shall vote on any case in which he/she is personally involved. A quorum of the committee shall consist of five physician members. Members of EXCEL staff attend the UM Committee to provide administrative support but do not have voting rights.

5.8 UTILIZATION REVIEW SUB-COMMITTEE

Utilization Review subcommittee meetings are ongoing and takes place on as needed basis to address overutilization or underutilization patterns and discuss focused specialty reviews based on UM findings/trends identified by UM team and PMGSJ Chief Medical Officer. PMGSJ/EXCEL MSO Chief Medical Officer, UM Committee Chairperson attend UM Subcommittee meetings. Individual physicians/providers are invited to attend meetings to discuss and resolve specific findings/deficiencies.

5.9 CHAIRPERSON, UTILIZATION MANAGEMENT COMMITTEE

The Utilization Management Committee chairperson is a contracted practitioner appointed by the Board of Directors. The Committee chairperson, in collaboration with the EXCEL Chief Medical Officer, plans and facilitates the Committee meetings. Other responsibilities may include program implementation and reporting to the Board of Directors on a quarterly basis.

5.10 CONFIDENTIALITY

All information involving the medical care of plan members shall be treated with the highest level of confidentiality to protect both the rights of the members, practitioners, and the medical group’s legal requirements that include the protection of peer review information. All members of the Utilization Management Committee, EXCEL staff members, and guests are required to sign a confidentiality statement in order to preserve plan member and provider

confidentiality. All records and proceedings of the UM Committee are considered as peer review, confidential and protected by California statutes.

5.11 PROGRAM EFFECTIVENESS

The effectiveness of the Utilization Management Program will be evaluated annually by the UM Committee. The Chairperson reports the evaluation results to the Board of Directors.

6.0 UTILIZATION MANAGEMENT PROCESS

To ensure the appropriateness of medical services, active participation by all practitioners and providers affiliated with the medical group is encouraged. Detailed utilization management activities that include active communication between the EXCEL staff and medical group representatives, practitioners, affiliating hospital and ancillary care providers are utilized. Only the EXCEL Chief Medical Officer/ Sr. Medical Director, or his/her physician designee may make decision to deny service or coverage. The types of review include:

Prospective Review - A process of reviewing and prior authorizing, pre-service/ elective service requests, both inpatient and outpatient, which meet established criteria and are medically appropriate for the member and the delivery system of care. Services include, but are not limited to specialty services, elective, inpatient/outpatient procedures, imaging, durable medical equipment, prosthetics/orthotics, and home health services. EXCEL performs pharmacy related prior authorization reviews as delegated by health plan, including oncology related Part B medications. Authorization of medical and pharmacy services follow CMS and ICE turnaround timeliness standards.

Concurrent Review - A process of reviewing and authorizing the care of members who are receiving inpatient services that meet the intensity and severity criteria requirements, are medically appropriate, and are being delivered at the appropriate level and setting. This includes – acute care hospital for commercial and Medi-Cal lines of business. Excel MSO understands that nationally developed criteria for length of stay are often designed with “uncomplicated” patients and a comprehensive delivery system that has sufficient alternatives to inpatient level of care. Complex cases or situations are carefully considered by Sr. Medical Director on a case by case basis and peer to peer conversations take place when needed with hospital physicians. Excel UM staff work closely with Health Plan UM staff to address discharge planning needs timely and appropriately.

Retrospective Review- A process used for the review of medical services that have previously been provided without prior authorization, to determine urgency, emergency, and medical appropriateness. If services are determined to be medically necessary, UM staff utilize Retrospective Review Process Policy and Procedures – UTM006, which indicates that the service may be authorized if submitted for authorization within 45 calendar days from the date of service.

6.1 PROSPECTIVE PRE-SERVICE/ ELECTIVE REVIEW (PRIOR AUTHORIZATION)

The primary care physician coordinates all care that is being rendered to the medical group members. The primary care physician or treating specialty provider may initiate and submit a referral request to EXCEL Utilization Management Department. After relevant clinical information has been received, the referral request is reviewed and a determination is made by the EXCEL UM staff, Chief Medical Officer/Sr. Medical Director or his/her designee. Three (3) attempts are made to obtain documentation/medical records from a requesting provider. These efforts are documented by non-clinical UM staff. If the patient is redirected from a non-contracted or tertiary provider to in network/contracted provider, prior authorization Nurse Case Managers place an ambulatory case management referral, to assist with coordination of care and ensure timely access to care. Ambulatory Case Manager contacts member and providers to assist with care coordination and documents efforts.

Consultations with the treating physicians and/or designated board-certified specialists may occur at the discretion of the Chief Medical Officer/Sr. Medical Director, or designee. All review decisions are made within the regulatory, NCQA, health plan, and ICE timeframes, but remain sufficiently flexible to accommodate urgent situations. Referral requests that do not meet established criteria may be further reviewed, at the discretion of the Chief Medical Officer / Sr. Medical Director, by the Utilization Management Committee or by specialists in the appropriate clinical discipline.

Female plan members may self-refer initially for obstetrical care and well woman examination, with a contracted provider, without prior authorization as outlined in the policy and procedure manual. Medi-Cal enrollees may receive obstetrics care from a contracted or non-contracted provider of their choice, as long as the provider is Medi-Cal credentialed. Members may self-refer for the delivery of sensitive services with either contracted or non-contracted provider, without prior authorization, as well. However, additional services may require prior authorization.

Prior-authorization is not required for mammography services when ordered by a nurse practitioner, physician assistant, certified nurse midwife, or physician, providing care to the patient and operating within the scope of practice for breast cancer screening or diagnostic purposes. Members can be seen without a prior authorization for consultation with contracted providers/specialists, with the exception of Dermatology, Ophthalmology, Podiatry, Physical and Occupational therapy, Speech Pathology, Acupuncture and Chiropractic specialties.

EXCEL prior authorization and concurrent review nurse Case Managers review authorization requests to identify PMGSJ Medi-Cal members - children under age of twenty-one (21) with potential CCS eligible conditions, and pediatric members

potentially eligible for the CCS Medical Therapy Program. Case Managers utilize California Children's Services (CCS) – CCS Medical Eligibility Guide to determine potential member eligibility for the program. EXCEL UM team obtain necessary documentation from the member's Primary Care Provider (PCP) or treating specialty provider and/or facility.

EXCEL Nurse Case Managers work with non-clinical UM staff to verify open CCS case and Service Authorization Request (SAR) status with Santa Clara County CCS staff. If no active CCS case exists, EXCEL staff submit SAR request for consideration. EXCEL UM team authorizes services for Med-Cal enrollees under the age of 21 based on medical necessity, utilizing Medi-Cal Provider Manual, Health Plan Evidence of Coverage and evidence-based guidelines, including but not limited to MCG, Apollo, NCCN and Health Plan guidelines. Authorizations are processed by EXCEL without delay in service, while CCS SAR is pending review.

EXCEL may assist Medi-Cal members transitioning from CSS pediatric care to adult care upon member reaching the age of 21, as needed.

EXCEL authorizes services included in the Early, Periodic, Screening, Diagnosis and Testing (EPSDT) program on behalf of Medi-Cal enrollees. Services include, but are not limited to speech therapy, occupational and physical therapy and other medically necessary specialty care services. Provision of medically necessary Behavioral Health Treatment (BHT) services for members diagnosed with Autism Spectrum Disorder (AS) under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and in accordance with mental health parity requirements is coordinated with the health plans. EXCEL MSO is not delegated to authorize behavioral health services on the health plans' behalf.

EXCEL UM staff coordinate authorization requests for other covered benefits, such as vision/optometry, hearing aids, inpatient and outpatient behavioral health, acupuncture, chiropractic, major organ transplant, transgender services to the delegated entities, by routing requests as directed by the health plans.

Authorization requests for covered benefits services are processed based on Division of Financial Responsibility (DOFR) and Division of Authorization Responsibility DOAR), which varies by health plan.

Requesting physicians are notified of the review decisions according to the regulatory, NCQA, health plan, and ICE time frames. Notifications to the requesting physicians/providers for denied services include the reasons for the denial, the criteria utilized and the availability of the EXCEL Chief Medical Officer/Sr. Medical Director to discuss the denials. Member notifications are mailed via postal mail to members in their preferred/threshold language at 6-8 grade reading level, depending on the line of business. Member notifications to members for urgent/expedited requests for service are performed via verbal

notification with three (3) attempts to reach member. This process is completed and documented within the authorization electronic system by non-clinical EXCEL staff.

6.2 CONCURRENT REVIEW

All non-urgent hospital admissions require prior authorization. The appropriateness of continuing inpatient stay is determined using appropriate guidelines to assist the inpatient concurrent nurse reviewer. All authorized length of stay decisions are based on medical necessity determinations made during the concurrent review process.

All urgent/emergency admissions are reviewed within one (1) working day after notification of admission. The participating hospitals are responsible to notify and provide clinical information to the EXCEL Utilization Management Department about the admissions. The EXCEL concurrent review nurse may perform initial and continuing stay reviews on site, telephonically, or remotely via the internet when available and appropriate. If the medical necessity for the admission is not established, the case is referred to the EXCEL Chief Medical Officer /Sr. Medical Director, or designee who will discuss the case with the attending physician(s) and/or the primary care physician to determine medical necessity as warranted.

The inpatient concurrent review nurse reviews and facilitates efforts to transition the members through the health care system continuum efficiently from admission to post-discharge. The nurse reviewer identifies and evaluates all inpatient stays on the date of admission or next business day for concurrent management and discharge planning, according to accepted guidelines. The concurrent review nurse works with the attending physicians, the primary care physicians, EXCEL Chief Medical Officer/Sr. Medical Director, hospital staff, ancillary providers, plan members, and families and contracted health plans to ensure that the inpatient stay is medically appropriate.

The inpatient concurrent review nurse also facilitates the access to other inpatient or outpatient services in timely manner in order to discharge patients from acute care facilities to a lower level of care. In addition, the concurrent review nurse is available to assist the attending physicians, primary care physicians, hospital case managers, plan members and families in establishing plans for post hospital care. The EXCEL Chief Medical Officer/Sr. Medical Director reviews inpatient cases with the concurrent review nurse on a regular basis and is available to discuss discharge plans with attending physicians, and primary care physicians on an as needed basis. The concurrent review nurse refers patients with complex medical and/or social needs to the complex case management nurse as necessary. The concurrent review nurse reports inpatient information to the health plans per contractual obligations. Concurrent review and/or complex case management cases may be reported and discussed during Utilization Management Committee meeting, when necessary.

6.3 RETROSPECTIVE REVIEW

Retrospective review includes two components: retro-authorization request review and retrospective utilization review.

Retro-authorization request review is performed when medical services were provided without obtaining prior authorization. Retro-authorization requests will be considered for authorization only under certain circumstances as described in a separate policy. If services are determined to be medically necessary, UM staff utilize Retrospective Review Process Policy and Procedures – UTM006, which indicates that the service may be authorized if submitted for authorization within 45 calendar days from the date of service. Requests for services submitted 45 days or greater from the date of services are forwarded to the Sr. Medical Director/Chief Medical Officer for review.

Retrospective utilization review includes the review of individual provider's referral patterns, appropriateness of referrals and procedures. The information is collected and analyzed on regular basis, at least annually. After conducting the retrospective utilization review, the individual provider maybe placed on focus review on a prospective basis to determine the future appropriateness and medical necessity of requested services.

6.4 COMPLEX CASE MANAGEMENT PROGRAM

The goal of the Complex Case Management Program is to enable members requiring complex and long-term medical interventions to achieve high quality health outcomes that are resource efficient and cost effective. The Complex Case Management Program process intends to assess medical care needs across the continuum of services and to analyze and measure the effectiveness of interventions in meeting the established goals.

Complex case management referrals are generated from multiple sources in order to identify individuals who require complex level of medical care including, but are not limited to, the inpatient concurrent review nurse, the referral authorization nurse, the quality management nurse, medical directors, primary and specialty care providers, members, hospitals and health plans. Potential cases referred to the complex case management nurse are reviewed and screened to determine if the cases are appropriate to be accepted for complex case management. The complex case management nurse performs the following key functions:

- Notifies and coordinates with the health plan case manager.
- Assesses the medical care needs, determines barriers and establishes treatment goals with the member.
- Develops treatment plans in conjunction with the primary care physicians and specialists, along with the members and/or designated caregivers.

- Facilitates the provision of necessary health services, including tertiary care, in an organized manner.
- Evaluates the treatment plan in relationship to the desired patient outcomes.
- Evaluates the care management interventions, designed to promote quality of care and quality of service, and appraises the effectiveness of interventions to the desired outcomes.
- Evaluates post-discharge transition of care needs.
- Documents the clinical course and outcome of the cases on an ongoing basis.
- Consults with the EXCEL Chief Medical Officer/Sr. Medical Director on a regular basis.
- Documents and closes cases after the medical problems that caused entry into case management program have been resolved and treatments and subsequent follow-ups have been completed.

The Complex Case Management Program is described in a separate Policy and Procedure.

6.5 TIMELINESS AND NOTIFICATION

Utilization management decisions are made in a timely manner, after all relevant information is obtained, and is respectful to the urgency of the condition or situation. Timeframes for pre-certification, prospective (preservice/elective) concurrent and retrospective decisions are made in accordance with the regulatory and accreditation agencies, such as Centers for Medicare and Medicaid Services (CMS), California Department of Healthcare Services (DHCS), California Department of Managed Healthcare (DMHC), National Committee for Quality Assurance (NCQA) and Industry Collaboration Efforts (ICE) standards.

Timeframe requirement for provider and member notification of determination decisions, by telephonic, electronic and/or writing, will be adhered to by the Utilization Management Department as outlined in the supporting policies and procedures.

For denied services, the physician reviewer is available for peer to peer discussion with the requesting provider as indicated in the written notification.

6.6 DENIALS AND APPEALS

All potential denials, including medical appropriateness denials are reviewed and determined by the EXCEL Chief Medical Officer/Sr. Medical Director, or physician designee. All written confirmation letters for denied decisions include the reason for the denial, criteria utilized, and instructions regarding the appeal process and expedited appeal process. All denials and appeals are logged, tracked and forwarded to the health plans as per contractual and regulatory requirements. Denial rates are reported to the Utilization Management Committee, Quality

Management Committee and Board of Directors and, if required, contracted health plans.

6.7 MONITORING OF OVER AND UNDER UTILIZATION

Utilization information is collected from multiple sources both internally, at EXCEL, and, externally, from the contracted health plans or contracted vendors, by a variety of mechanisms. On a periodic basis, this is reviewed, analyzed and reported to the Utilization Management Committee, Quality Management Committee and Board of Directors. Opportunities for improvement are identified with appropriate improvement plans for implementation and follow-up. These utilization reports are reviewed for over and underutilization and reports may be provided to the health plans according to the contractual requirements.

On a regular basis throughout the year, utilization profiles of individual providers, primary care and specialty care, are collected and reported. The profiles may include referral rates, emergency room and urgent care center utilization, per member per month medical cost, and/or diagnostic or surgical procedure rate. Results of these individual profiles are compared within each specialty group, both primary care and specialty care specialties, as well as with health plan and national benchmarks. Upon completion and analysis, individual provider will be provided with his/her own comparative results. Individual provider results, as well as specialty group results will be presented to the Utilization Management Committee and the PMGSJ Board of Directors. Areas of potential improvement will be identified. Improvement activities will be formulated and implemented.

PMGSJ Board of Directors or committee may also request specific practitioner or procedure utilization report when there is concern with the over and underutilization.

6.8 CONTINUITY OF CARE

Physicians Medical Group expects all contracted specialists, primary care physicians and practitioners to cooperate with the continuity of care efforts that promote high quality effective medical care. Health Plan or County Behavioral health specialists, with written consent from the member, will collaborate with primary care physicians in order to provide safe, appropriate and coordinated health care. EXCEL Case management team may act as a liaison to address continuity of care (COC) and coordination of care needs, including behavioral health, as needed. Continuity of care is determined by UM clinical staff, by following PMGSJ Continuity of Care Policy to authorizer COC requests on behalf of Seniors and Persons with disabilities (SPD), Medi-Cal enrollees, including Medical Exemption Requests (MER), and Cal MediConnect beneficiaries. Other PMGSJ members who may have had established care with a non-contracted provider, may be authorized to receive care under COC based on medical necessity and COC policy.

Physicians Medical Group of San Jose and EXCEL MSO, LLC will coordinate with the health plans in order to provide continuing health care to members with specific conditions, who have been receiving care from a terminated provider, for a period of time in accordance with regulatory agencies or until a safe transfer to new providers can be arranged.

7.0 COMMUNICATION SERVICES

Members and practitioners can access staff to discuss UM decisions. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. UM staff can receive inbound communication via telephone and facsimile during normal business hours. Staff can receive inbound communication via telephone/voicemail, fax after normal business hours; communication is addressed next business day. Communications received after midnight on Monday–Friday are responded to on the same business day. When initiating or returning calls regarding UM issues, EXCEL UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. TDD/TTY services are available. EXCEL MSO utilizes health plan language assistance/interpreter line for members to discuss UM issues in the member's preferred language.

8.0 UTILIZATON MANAGEMENT POLICIES AND PROCEDURES

Components of the Utilization Management Program are supported by individual policy and procedure which outlines the process in details.

9.0 CONFIDENTIALITY

All members of the PMGSJ Utilization Management Committee and EXCEL staff are required to sign a confidentiality statement at least annually. The confidentiality statement will be kept on file at the offices of EXCEL MSO. All Utilization Management Committee records and proceedings are confidential and protected as provided by Section 1157 of the California Evidence Code, whether or not marked: "Confidential and protected as defined by Section 1157 of the California Evidence Code". Signed minutes are maintained in a locked file in the EXCEL MSO LLC offices, available only to authorized persons.

Utilization Management Committee minutes and documents may be reviewed by authorized health plan representatives. However, no copies will be provided and confidentiality of the information will be preserved.

10.0 FINANCIAL INCENTIVE

During the course of Utilization Management Committee activities, there may involve incidents where utilization management decisions are made resulting in denial or recommendation of denial of services. The EXCEL Utilization and Quality Management staff, PMGSJ Utilization and Quality Management Committee, and PMGSJ Board members are not incentivized or reimbursed for adverse decisions relating to utilization management decisions. The utilization management decision is independent and impartial and is solely based on appropriateness of care and service and existence of coverage.

11.0 UM SYSTEM CONTROLS

EXCEL MSO implemented system controls to protect data from being altered outside of prescribed protocols and from unauthorized modification. EXCEL MSO requires each individual UM staff to establish a username and a strong password in order to access UM authorization/claims system. Two step authentication process is in place for UM staff in order to log into the computer. Passwords are required to be changed periodically. UM staff are prohibited from sharing their username and passwords. UM staff are required to protect Personal Health Information (PHI) by locking/logging off their computer stations prior to stepping away from the computer. Once an employee leaves the organization, all access to UM information is disabled immediately upon termination.

To protect data integrity, certain fields of the authorization may not be edited or modified, such as authorization request date of receipt, UM staff and Medical Director clinical review date and time, decision date and time, written fax notification to provider. All documentation within an authorization is electronically date and time stamped by the UM system.

Batch mailing of approval letter date and time may not be modified. Manual written provider and member notification mailed letter date/time can be modified by UM coordinators, as they manually enter these dates into the system.

Authorization may be modified by UM Director/Manager of Health Services as part of an overturn/appeal/grievance/peer-to-peer process to update quantities/units/visits, CPT/HCPS codes, rendering provider or to extend the validity of the authorization – valid from/to dates. This is done on a case by case basis.

Once the authorization request has been approved, it will not be changed. The only allowable changes are for correction of CPT4 coding or site of service at the request of the requesting provider. These changes may only be made by clinical staff. Changes are tracked in the authorization audit trail.

UM Coordinators may extend/modify an approved authorization valid from/to dates when requested by provider's office for a thirty (30) day period, if member continues to be eligible with PMGSJ.

Policy and Procedures
Operating Manual

Policy Title:	Utilization Management Program	**Policy No.:**	UM 2.0
Replaces Policy Title *(if applicable)*	N/A	**Replaces Policy No.** *(if applicable)*	COM 5701
Department Owner	UM	**Policy Review Frequency:**	Annually or as needed
Department Applicability	Claims, Information Services, Member Services, Provider Relations Department		
Lines of Business *(check all that apply)*	☒ Commercial ☒ Medi-Cal ☒ Covered CA ☒ IFP		
Accreditations *(check all that apply)*	☐NCQA	☒AAAHC	☐ _____

I. POLICY

VHP is committed to providing members with comprehensive medical and behavioral health services that are appropriate, timely, and effective. VHP's Utilization Management (UM) Program is an important element to fulfilling this commitment.

II. PURPOSE

The goal of the UM Plan is to maintain a UM Program that ensures timely, appropriate and medically necessary health care services for VHP Commercial Members and to the SCFHP delegated MCMC, Healthy Families and Healthy Kids members.
The objectives of the Plan are to:

- Assure that physical care services are consistent with accepted medical practice and community standards of care.
- Assure that behavioral health care services are consistent with accepted medical practices and community standards of care for the VHP Commercial Members.
- Administer the UM Program in a manner that facilitates efficient member care and access and promotes fair and consistent decision-making.
- Monitor provider practice patterns to identify opportunities for improving the delivery of care to VHP members.
- Identify and refer members who would benefit from case management.
- Educate members and providers about the UM Program, UM processes, and review criteria.
- Coordinate the UM Program with the QM Program.

III. DEFINITIONS

Clinical Guidelines: Systematically developed descriptive tools or standardized specifications for care to assist practitioners in treatment decisions about appropriate health care for specific clinical circumstances. Clinical guidelines are typically developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus.

Nationally Recognized Review Criteria: Systematically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcomes. Criteria are typically developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus.

Health and Hospital Committee (HHC): The governing body responsible for quality assurance and utilization management programs and the approval of administrative policies and procedures.

Medical Necessity: The determination that intervention recommended by a treating practitioner is (1) the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and (2) known to be effective in improving health outcomes.
For interventions not yet in widespread use, a Plan determines effectiveness based on the best available scientific evidence.
For established interventions, a Plan determines effectiveness based on scientific evidence, professional standards and expert opinion."

Quality Management (QM):
The QM program seeks to ensure Valley Health Plan (VHP) members have access to and receive timely health care including medical and behavioral health care that meets their needs and adheres to recognized standards of care. The program objectively evaluates and seeks continuous improvement in all areas related to quality, including health outcomes, practitioner/provider access and availability, behavioral health care, utilization appropriateness, member and practitioner experience (satisfaction), and grievance resolution. VHP fosters an environment of patient safety through quality initiatives, member and practitioner education, promoting best practices and healthy patient outcomes. The program closely monitors and promptly incorporates relevant statutory, regulatory and accreditation changes, and promotes a setting in which all services are provided in a culturally and linguistically appropriate manner.

Quorum: The minimal number of voting members of a committee or organization. Accepted UMC quorum is >50% of all MD members.

Quality Management Committee (QMC):

The QMC has a responsibility to oversee the Quality Management program. The annual QM work plan provides further details of the distinct activities undertaken for the membership.

Santa Clara Valley County Hospital System (SCCHS): Full service, County Operated Facility providing a wide range of primary and specialty medical services and overseeing public programs for the health and well-being of all County residents, regardless of their ability to pay. SCCHS includes Valley Medical Center, O'Connor and St Louis Reginal Medical Center.

Utilization Management (UM): The evaluation of the appropriateness, medical need and efficiency of health care services, procedures, and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan.

Utilization Management Committee (UMC): The UMC is responsible for tracking and monitoring utilization issues and instituting corrective action for the Plan.
- Examines utilization issues brought to it by the medical director
- Approves or reviews policy regarding coverage
- Reviews utilization patterns of providers
- Approves or reviews the process of sanctioning providers because of their utilization
- Tracks, trends and compares member utilization year to year.

Valley Health Plan (VHP): A Knox Keene Licensed HMO, providing medical insurance to Commercial and Managed Care recipients.

VHP Network: A health care delivery service system within the Service Area. A Plan Network is made up of Plan Physicians (such as Primary Care Physicians [PCPs] and Plan Specialists), Plan Facilities, and Plan Hospitals.

- Within Network: all contracted providers through VHP; SCVHHS are the preferred care providers within VHP's Network.
- Out of Network: non-VHP contracted providers.

IV. RESPONSIBILITIES:

Department of Managed Health Care (DMHC): The Department of Managed Health Care (DMHC) was created by the California Legislature in 2000 to help ensure high-quality health care for the nearly 21 million people who belong to managed health care plans.

The Health and Hospital Committee (HHC) of the Santa Clara Valley Health & Hospital System (SCVHHS)

- Oversees the UM Program
- Approves some policies, procedures, and program changes
- Delegates responsibilities, when appropriate, to the QMC, VHP's Medical Director, and/or the UMC. New policies may be operationalized after being signed by the Medical Director or VHP's CEO.
- Meets with VHP every other month.

Quality Management Committee (QMC)

- Develop and maintain the annual QM program description and annual QM Workplan. Review and revise the scope, objectives, organization, and effectiveness of the program at least annually. Recommend policy changes, review, and evaluate results of quality improvement activities, initiate program improvement and ensure follow-up, as appropriate.
- Review and approve all UMC meeting minutes.
- Select routine monitoring activities, special studies, which are both relevant to the membership's demographic and epidemiological characteristics and have a potential impact on the populations served.
- Establish standards and performance goals. Monitor and evaluate through qualitative and quantitative analysis for the attainment of these standards and objectives. Monitoring of information with the goal of detecting trends and performance patterns.
- Ensure corrective actions are implemented, as needed.
- Ensure that appropriate follow-up occurs on all issues of concern.
- Communicate and coordinate with other VHP committees, departments, and programs in areas that pertain to the quality of care and service to members and practitioners.
- Coordinate peer review activities when appropriate and necessary. Review findings pertinent to individual practitioners and providers
- Guidelines are used for preventive care, clinical practice utilization management and behavioral health care which are based on scientific evidence. Guidelines are used to ensure the effectiveness of clinical care (e.g. HEDIS)

Utilization Management Committee (UMC)

- Responsibility for implementing the UM Program to the UMC. The UMC is directly responsible for all UM activities and reports on the UM activities to the QMC.
- Responsibilities include:
  - Provides expert advice on UM activities
  - Serves as an advisory body for monitoring services utilization

- Makes recommendations to the Medical Director and the QMC on UM activities.

- UMC Selection Process
  - The UMC Chairperson is the Medical Director or designee.
  - His/her appointment is reviewed and ratified by the UMC
  - The Committee Chairperson will select the physician committee members.
  - Members will serve for a period of one year although their membership may be extended as requested by the Medical Director and ratified by the UMC, if the Chair is not the Medical Director.
- Responsibilities of the UMC
  - Reviews and approves annually the UM Program's plan, policies and procedures including the criteria used to make medical necessity decisions. As new and/or modified UM policies and procedures are developed, they are submitted to the UMC for review and approval.
  - Evaluates annually the effectiveness of the UM Program. The data used to evaluate the program includes but is not limited to member and provider satisfaction survey data, staff interviews, utilization data, and other information as appropriate.
  - Approves a work plan each year that includes a schedule of activities for the year with measurable objectives
  - Based on utilization data obtained from management information reports, recommends special studies to review areas of concern and to identify utilization and/or quality problems
  - Reviews potential inappropriate utilization and practice problems and recommends corrective actions. As necessary, provider issues are referred to the Provider Review and Credentialing Committee.
  - Reports quality of care, service, and improvement issues that arise from UM activities to the QMC
  - Evaluates the appropriateness of new technologies or the new application of established technologies
  - Develops strategies to communicate with and educate providers
  - Ensures compliance to DMHC regulations
- Approval Process
  - The UMC operates by a quorum for voting. A quorum is >50% of all MD members or as determined by the Chair.
  - Approval requires a quorum of Physicians.
- Meetings and Minutes
  - The UMC meets no less frequently than quarterly.
  - UMC Chairperson will chair at each meeting to promote the members' understanding and execution of the UM Plan and Program.
  - Minutes of the UMC meeting includes the following subjects:
    - UM issues
    - Follow-up of corrective action
    - Results of UM activities
    - Target dates to report back to UMC.
  - To ensure follow-up on all agenda items, a tracking system is used and items are carried over on the agenda until resolution.
  - All activities of the UMC are documented in the meeting minutes. The minutes are reviewed and signed by the UM Chairperson and approved by the UMC.
  - UMC minutes are confidential and kept on file at the Health Plan office. The minutes are submitted for review and approval by the QMC and are available to the HHC and or regulatory agencies required.
  - The yearly review and update of the UM program is reflected in the UMC minutes.

UMC Members

- Membership Includes:

- VHP Medical Director or designee who serves as Committee Chairperson
- VHP Chief Executive Officer (CEO)
- At least two physicians from primary care- (Internal Medicine, Pediatrics, Family Practice, or specialty services such as OB/GYN)
- Community Clinic representatives
- Behavioral Health Medical Director
- UM Manager and or designee
- Representative from Provider Relations and Member Services Departments
- Representative from Quality Management

- Voting rights – only Physicians on the UMC have voting rights

UM Department

- Under direction of the Medical Director and UM Manager, carries out the utilization management activities outlined in this Plan including reviewing and authorizing medical services.
- Maintaining utilization activity data used to evaluate the effectiveness of UM strategies and to identify individual cases of over and underutilization as well as utilization patterns and trends.
- The VHP Medical Director and the UM Manager have day-to-day responsibility for the UM Program activities.

Quality Improvement Manager

- The QI Manager assists and oversees the implementation of the QM program and annual QM work plan under the direction of the CMO, QM Committee, and Medical Directors.
- The QI Manager assigns dedicated staff members to the QM program and recruits additional staff as necessary to meet QM needs.
- The QI Manager, along with QI staff monitors, analyzes, and reports internal and external data trends and patterns that affect the quality of care and service delivery.

VHP Medical Director

- The Medical Director is appointed by the Health Plan CEO and approved by the HHC. The Medical Director is a licensed physician with both Medi-Cal and managed care experience.
  - Reports the Health Plan activities to the HHC
  - Serves as the lead clinical authority and oversees the UM activities
- The Medical Director or his/her designee
  - Reviews, evaluates, and presents utilization reports
  - Be available for the Utilization Review Coordinators, (URCs).
  - Only the Medical Director is his/her designee may deny medical service requests for medical necessity
  - Serves as liaison between the UMC and other committees, contracted health plans, hospitals, physicians, and staff.
- Works with the VHP UM Manager
  - Chair the regular meetings for the VHP UM Committee
  - Prepare meeting agenda and review minutes
  - Provide pertinent follow-up for utilization management issues
- Provides leadership and assistance where appropriate for the ongoing and planned studies of Health Plan utilization. This will include ongoing tracking and trending in identification of areas: in-patient hospitalization, outpatient visits, emergency department utilization, utilization of referrals to specialists, utilization of pharmaceuticals.
- Is familiar with UM analytic techniques, data extraction, and reporting
- Maintains on-going knowledge of trends in improving utilization patterns as practiced by medical organizations
- Identifies best practices as they relate to health plan utilization
- Provides leadership and assistance in the ongoing development and regular updating of

  - Referrals guidelines
  - Disease management guidelines
  - Standards for routine health maintenance and screening as they relate to plan members' health care
  - Practice patterns of plan physicians and other providers.
- Serves as a resource for making decisions and authorizations of health plan services. Serves as a member of the appeals committee in the re-evaluation of decisions relating to utilization.
- Develops local criteria when such criteria are not otherwise available.

Associate VHP Medical Director for Behavioral Health

The Associate Medical Director for Behavioral Health UM has ongoing responsibility for key elements of the Behavioral Health UM Program.

- Coordinates UM activities with the Assistant Medical Director
- Provides clinical guidance to the UM staff regarding behavioral health issues
- Chairs a Behavioral Health Management group which develops policies and recommendations to UM and QM
- Chairs Behavioral Health Advisory Group
- Works with the Assistant Medical Director and UM staff to develop and refine behavioral health referral and authorization criteria
- Reviews, approves, denies or modifies authorization requests for all behavioral health services
- Coordinates UM activities with the Assistant Medical Director
- Develops periodic reports to UMC for patterns of over and under utilization
- Works with the Medical Directors and local professionals to develop criteria when necessary
- Identifies additional professional resources for second opinions or back-up when needed

Behavioral Health Advisory Group

Includes professionals from the VHP behavioral health network and the addictive medicine network. Responsible for reviewing Behavioral Health policies and procedures.

Utilization Management Program Manager

- In conjunction with the Medical Director, and Assistant Medical Director is responsible for the overall development and management of UM operations, program, minutes, UM planning, program strategies and Data development and analysis. Ultimately responsible for final claims on all transactions as well as overall quality control of the department.
- Develops system-wide relationships and interfaces to coordinate the management of patients and resources throughout the entire network including all components of patient care
- Ensures the effectiveness of VHP UM operations and develops interventions where necessary to improve service to patients and physicians
- Implements system for monitoring compliance with all Federal, State and County regulations and agency requirements.
- Evaluates the UM program annual priorities and indicators for department performance
- Reviews adequacy of UM Committee and follows-up with interventions to improve access, quality of care, and patient satisfaction
- Evaluates performance of UM program and his/her evaluation/management of staff
- Provides oversight of Plan compliance to Federal, State, and County regulations

UM Department Supervisor

- Responsible for the day-to-day operational implementation of the UM Program under the direction of the UM Program Manager.
- Supervises the UM staff which includes the URCs
- Consults with the Medical Director, Assistant Medical Director, and Associate Medical Directors and/or UM Program Manager about authorization issues

- Monitors and audits the activities of the UM Department to assure compliance with VHP policies and procedures and state and other regulatory requirements
- Coordinates operational interface between UM and other VHP and Managed Care Departments
- Generates operations reports which include but are not limited to workload and performance statistics, compliance evaluates, Anti-Fraud reports and annual reports
- Conducts annual evaluations of all staff UM compliance with County policies
- Develops, implements, and documents annual UM Department goals, objectives and work plan.

Utilization Review Coordinators (URC)

- Primarily responsible for ensuring oral requests for authorizations are expedited to ensure patients access to care as well as providers needs are met.
- Identifies or is assigned complex cases to manage effective and timely interpretation of appropriate resources and access to care
- Collaborates with providers to assist with patients care coordination and/or difficult and complex medical conditions
- Identifies and reports access, consumers and provider issues or network problems to supervisors, program manager or Medical Directors for resolution as appropriate
- Adheres to Department protocols and procedures

Administrative Support

- Assists authorization activities including prioritizing authorization requests
- Processes authorization requests using screening guidelines
- Creates Diamond records
- Generates notification letters.

Medical and Behavioral Health Specialist

- Providers from a wide range of specialty areas are available the UM Department as needed.
- For services where there is inadequate or no established criterion, the Medical Director may refer the authorization request to a network physician who is considered an expert in his/her field for his/her input and consideration.

V. PROCEDURES

A. Scope

Key aspects of service addressed in the UM Program are medical necessity, appropriateness, availability, and accessibility of health services. Since all VHP services are offered in the context of a defined benefit plan, an additional but critical aspect of service addressed in the UM Program is the efficiency of services to members.

Utilization Management is an on-going process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the utilization of health care services for Valley Health Plan members, Commercial and Delegated Members. The UM Department, responsible for this function, is staffed with licensed health care professionals who obtain pertinent clinical indications and medical record information necessary to perform thorough assessments of requested referrals and service authorizations. The licensed UM staff is responsible for applying utilization review criteria and guidelines to individual cases and for referring to the Medical Director(s) when criteria are not met for medical necessity decisions.

The UM Committee oversees the UM Program and is charged with evaluating the effectiveness of the UM Program annually; regularly analyzing UM data for trends and patterns; and developing strategies to address issues identified. To further ensure program effectiveness, the VHP UM Program maintains written policies, procedures and protocols that define program accountability activities, and processes.

The UM Program addresses health care services provided in both inpatient and outpatient settings, services inclusive of home health and ancillary services and care that are acute and chronic. The program also addresses Commercial Members utilization for Behavioral Health which includes mental health and addictive medicine.

Review activities include:

- Authorization of office, ambulatory, inpatient, and ancillary services.
- Referral Management
- Out-of-Area/Emergency Services Management
- Case Management
- Second opinions
- Provider Communication and Education
- Utilization Data Management and analysis
- VHP UM Department performance.
- Grievances and Disputes.

B. Processes

Utilization Management Processes:

1. UM Department Activities:
    a. Verify member eligibility and benefit coverage
    b. Ensure timely processing of authorizations, consistent with benefits and existing contracts
    c. Ensure requested hospitals and providers are contracting providers
    d. Evaluate medical necessity, level of care, treatment setting, and appropriateness of the proposed treatment plan
    e. Coordinate approved out-of-network requests
    f. Monitor VHP members admitted to local and out-of-network hospitals and facilities
    g. Coordinate transfer of VHP members to network providers, as appropriate
    h. Document reasons for the UM decision including the information obtained; contact(s) with the requesting provider and PCP; and the criteria used to approve or deny the authorization request
    i. Ensure Turn Around Time (TAT) standards are maintained
    j. Identify patients needing case management
    k. Report access or quality issues with the network
    l. Assist with educating and providing information to physicians and other network providers
    m. Identify and facilitate referrals to Social Worker, Health Education, Member Services, Provider Relations or other Departments to assist patients and providers
2. Services Not Subject to VHP UM Prior Authorization
    a. Emergency Services–hospital emergency room services to stabilize an emergency physical or mental condition including emergency ambulance services.
    b. Member Choice– self-referral for Sensitive Services (for delegated products only). Sensitive Services include the following:
        - Family Planning
        - HIV Confidential Testing/Counseling Services
        - STD Diagnosis and Treatment
        - Sterilization
        - OB/GYN Services (within network)
    c. Behavioral Medicine counseling services including addictive medicine services in network
    d. Telehealth via MDLive
3. Provider Responsibility
    a. The Primary Care Provider (PCP) is responsible for referring patients for appropriate specialty care and elective inpatient and outpatient services. The list of services requiring authorization is noted in Policy UM 19.0 and Section 11 of this document.

b. Non-SCCHS providers including out-of-network hospitals are responsible for securing appropriate prior authorization from the UM Department. Providers may be financially responsible for services that are non-authorized.
c. If a member presents at a non-SCCHS hospital for other than outpatient emergency services, the hospital is required to contact the UM Department for authorization.
d. Management of addictive medicine services is delegated to the Santa Clara County Department of Alcohol and Drug Services.

4. Review Requirements
    a. PCPs must utilize health care services provided by VHP's contracted provider network and/or providers approved through the UM process (except medical emergencies).
    b. Requests that do not meet the review criteria are reviewed by the Medical Director or an Associate Medical Director.
    c. Except for eligibility or benefit coverage denials, all denials and/or modifications to treatment authorization requests are made by the Medical Director or an Associate Medical Director.
    d. The PCP must submit an electronic authorization request or complete a Treatment Authorization Request Form and fax/email/mail it to the UM Department. Information provided should include:
        - Diagnosis
        - History and clinical findings
        - Purpose of the service
        - Results of evaluation and diagnostic studies
        - Lab and/or x-ray results
        - Product
        - Identification of the member
5. Annual Reviews – The criteria used in the UM Program are reviewed annually and approved by the UMC.
6. Utilization Management Criteria
    a. Use of Nationally Recognized Review Criteria: The UM review staff use nationally recognized medical review criteria to assist them in reaching decisions on medical necessity and clinical appropriateness.
        - Apollo
        - MCG Care Guidelines
        - Medi-Cal Manual of Criteria for Medi-Cal Authorization
        - Medi-Cal Program References
        - National specialty boards, published guidelines, clinical studies
        - Medicare CMS regulations
        - Med Impact, Harvard Pilgrim medical necessity criteria and/or Epocrates and MicroMedex.
    b. Local Criteria (Services not found in the criteria sets)
        - The Medical Director or Medical Director Designee initiates the development of local guidelines or criteria when the criteria set listed in "a" above do not address a health care service or do not reflect community practice. These also include Clinical Practice Guidelines adapted by the Plan.
        - As part of the development process, the proposed medical criteria are reviewed to ensure the criteria are based upon published evidence and sound clinical principles. The recommended guidelines/criteria are then submitted to the UMC for approval.
7. Application of Review Criteria

    It is recognized that nationally developed guidelines are often designed for the uncomplicated patient. Therefore, the following factors may be considered when applying criteria to the individual member:
    - Age

- Co-morbidities
- Complications
- Progress of Treatment
- Psychosocial situation
- Home Environment
- Member desires
- Ethnicity /Culture/Language
- Religion
- Other

8. Access to Review Criteria
    a. Providers may obtain review criteria by contacting the UM Department.
    b. Evidence of Coverage, provider newsletters, and provider contracts inform providers and members about the procedure for obtaining copies of the criteria used by VHP in its review program.
    c. Valley Express
9. Review Timeliness
    Authorization requests are handled in a timely manner and take into consideration the nature of the member's medical situation. When necessary (the member's condition is such that the insured faces an imminent and serious threat to his or her health or would be detrimental to the member's life or health or jeopardize the member's ability to regain maximum function), the reviews (initial determination and appeals) are expedited. Authorization Turnaround times are outlined Policy UM 10.0
    a. Emergency authorizations –prior authorization is not required for the Emergency Room visits, but prior authorization is required for admission to a non-SCCHS hospital. Claims for these services are reviewed retrospectively.
    b. Urgent pre-service authorizations are reviewed and responded to within 72 hours of the receipt of medical information necessary to make the decision. The urgency of the situation is taken into consideration.
    c. Urgent Concurrent requests (inpatient hospital admission) are reviewed and responded to within 24 hours of the receipt of medical information necessary to make the decision.
    d. Routine authorizations are reviewed and responded to within 5 business days of VHP's receipt of all relevant information.
    e. Retrospective review of services (services have been rendered) are completed within 30 calendar days of VHP's receipt of all relevant information.
10. UM Decision-making Authority
    a. UM Program Manager – Licensed Registered Nurse
        - Must be a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider.
        - Oversees and organizes the Utilization Management and Case Management activities to oversee the medical necessity for in-patient admission including transfer of members from out of plan facilities back into network, and the continuity and co- ordination of care of the members of Valley Health Plan.
        - This includes but not limited to:
            - Data collection and interpretation, review and development of policy and procedures
            - Organization of Utilization Management Department and Utilization Management Committee Meetings
            - Activities to ensure compliance with all regulatory authorities (DHCS, DMHC, MRMIB, Accreditation Standard, etc.).
    b. UR Supervisor (URS) – Licensed Registered Nurse
        - Must be a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider.

- Direct, supervise, train, and manage nurses in accordance with organizational expectations, ensuring that medical management operations are effective, appropriate, timely and compliant with internal and external expectations for all lines of business.
- Ensure proper staff training and use of evidence-based criteria such as MCG Guideline to assess medical necessity and appropriate levels of care for admissions and discharge.
- Oversees case management activities performed by Registered Nurse Case Managers and Medical Social Workers. Assures case management services are provided using the recommended Care Guidelines and Criteria for Managed Healthcare Standards of Care.

c. UM Assistant (non-licensed)
- In order to utilize UM personnel efficiently and focus licensed staff on their unique skills and qualifications, the UM Assistants have the authority to approve services listed in the UM Assistant Directives Document. This document is created and maintained by the URS.
- The UM Assistants do not render any medical necessity decisions requiring clinical training.
- The UM Screening Guidelines are regularly reviewed and approved by the Medical Director.

d. Utilization Review Coordinators (URCs) – VHP's Licensed Registered Nurses
- The URCs are authorized to approve services falling outside the scope of services handled by the UM Assistants and meeting VHP's approved review criteria.
- The URCs used medical necessity criteria and VHP MD Directives to assist in the decision-making process. The VHP MD Directives are created and maintained by the UM Manager and/or UM Supervisor.
- The URCs do not make medical necessity denials.

e. Medical Director or an Associate Medical Director
- Medical Directors review any services brought to their attention by the UM Department staff including those that do not meet review criteria.
- Medical Directors are Board-certified physicians licensed in the State of California and practice at SCCHS.
- All authorization or modifications or denials made by the medical director or associate medical director must be documented according to nationally recognized criteria.

11. UM Review Methods

a. Prior Authorization
- At least 5 working days prior to a planned service, the primary care physician initiates an authorization request by submitting an electronic request via Valley Express or a Treatment Authorization Request Form (TARF) to the VHP UM Department. See Attachment A
- If insufficient information has been provided the provider may be contacted electronically via Valley Express to gather relevant clinical information needed to review the authorization request.
- If the criteria are not met, the request is referred to the Medical Director or his/her designee to make the medical necessity determination.
- The Medical Director at his/her discretion can consult with a specialist or request the member to obtain a second medical opinion.
- The review decision is faxed, emailed or mailed to the provider within 24 hours of decision.

b. Concurrent Review (also referred to as Continued Stay Reviews)
- Concurrent Review is performed to continually assess the medical necessity and appropriateness of inpatient care.

- Concurrent Review include but are not limited to:
  - Acute hospitalizations and Long-Term Acute Care (LTAC) hospital admissions
  - Behavioral health admissions
  - Acute rehabilitation services
  - SNF/LTC admissions
  - Hospice inpatient services
- Concurrent reviews are performed daily with the hospital UM Departments. The review intervals may be longer for admissions with long lengths of stay.
- The URC reviews member's medical records, consults with the attending physicians or other members of the health care team.
- The URC identifies discharge planning needs on the first day of hospitalization or as early as possible. If the member has post-discharge needs, the URC will authorize and coordinate the post-hospital plan of treatment.
- If the member is hospitalized in a non-SCCHS facility, the URC will make arrangements for safe transfer to a SCCHS when the member is determined to be medically stable for transfer.
- The URC collaborates with CM staffs and assists hospitals and other facilities with discharge planning by authorizing post-hospital services and arranging for service delivery through network providers.

c. Retrospective Review
- Retrospective request may be accepted for review when submitted within 30 calendar days from start of care date. Medical records are requested as needed to determine the medical necessity, appropriateness of the setting, and length of stay. Exception may be made due to extenuating circumstances such as:
  - ✓ Emergent services
  - ✓ Prior authorization was not available

d. Medical Claims Review (Pre-payment Review)
Claims may be reviewed by the URC's for the reasons listed below:
- Services that were not prior authorized
- Medical necessity of billed services
- Unbundling of charges
- Appropriateness of coding
- Unusual Pricing or billing practice
- Member appeal
- Provider appeal
- Emergency services
- Quality of care issue

AUTHORIZATION REQUIREMENTS

No Prior Auth Required	• Routine lab work, Ultrasound, and radiology • Services provided by Primary Care physician (PCP) and within PCP's scope of practice • Emergency room services • Emergency Ambulance services • Self-referred services to contracted providers such as MH counseling, OB/GYN • Sensitive services (for Managed Medi-cal members) • Telehealth (via MDLive)

Prior Authorization Required	• All services provided by non-contracted providers • Services or procedures performed by specialist providers • All elective admissions • Out-of-area services • Non-formulary drugs, plastic surgery, and Post stabilization admissions to Non SCCHS hospitals • All DME, orthotics, and prosthetics ordered by any provider
Plan Notification Only	• Facility Admission when VHP is secondary insurance
Concurrent Review	• All acute hospitalizations • SNF/LTC admission • Inpatient Hospice services • Mental health inpatient admission
Retrospective Review	• Emergency room admissions and related services • Out of service area, services

12. Denials and Reconsiderations
    a. Any decision by a Medical Director to deny plan benefits for any medical service, procedure, or specialist consultation is considered a denial.
    b. Any denials based on medical necessity are made by a Medical Director or Associate Medical Director.
    c. Providers receive a notification letter by fax or email within 24 hours of the decision; members are notified in writing within 2 business days. If members are hospitalized, the notification occurs within 24 hours.
    d. A modification to an authorization request is a form of denial and will be processed as a denial.
    e. The Medical Director clearly documents the clinical rationale for medical necessity determinations.
    f. The denial or modification notification includes the following information:
        - Type of review that was done
        - Specific medical reasons for denial as documented by medical necessity standards. See policy UM 25.0
        - Clear and concise language. See policy UM 10.0
        - Services denied
        - Date benefits are denied
        - An explanation of the appeal process
        - Name and telephone number of the physician who made the determination
        - The required state phone numbers, Internet address, and plans telephone number in 12-point boldfaced type
        - Notice of Action (NOA) letters will conform to format and language as required by DHCS
        - Process and directions to contest a denial/modification
        - Contact information for DMHC
    g. Denial information is maintained in hardcopy and or electronic file and documented in the “notes” field of the Diamond authorization module or in Valley Express.
    h. Reconsiderations of a denial are processes to re-review the initial determination. It is offered to providers and members when they can present additional medical information that was not available for the initial determination.
13. Member and Provider Notification of Review Decisions
    a. The provider is faxed and/or e-mailed a notification letter within 24 hours of the authorization decision. In urgent cases, the provider is notified by telephone.
    b. The member is mailed a notification letter within 2 business days of the authorization decision. The provider also receives a hardcopy of the member letter by mail or facsimile.

c. Denial and modification letters contain information about grievance/dispute procedures in case the member or provider disagrees with the authorization decision.
d. Denial letters conform to the requirements of the California Health and Safety Code section 1367.01(h) (3).
e. Denial notifications are available in English, Spanish, and Vietnamese, depending on the language preference of the member.

14. Case Management
    a. The goal of the Case Management program is to improve the health outcomes for members with complex medical conditions while using resources efficiently.
    b. In the case management process, care needs are assessed and managed across the entire continuum of care.
    c. Cases are identified from a number of sources including, but not limited to, Health Risk Assessment, Member Outreach program, authorization requests and claim data. Providers and members may also refer members/self-refer for case management. See UM 1.0 Case Management
    d. Eligible cases are not limited to selected diagnoses.
15. Second Opinions
    a. Second medical opinions are a covered service and required prior authorization.
16. Continuity of Care for Members
    a. To ensure continuity of care, new members may request to continue services with a non-participating provider for a reasonable transition period before being transferred to a participating provider (Policy UM 42.0).
    b. Requests to continue services with an existing non-participating provider are made to the UM Department and reviewed by VHP's medical directors.
    c. The Medical Director conducts a case-by-case analysis and considers the severity of the enrollee's condition and the amount of time reasonably necessary to affect a safe transfer. Also considered, will be the potential clinical effect that a change of provider would have on the enrollee's treatment for the condition.
    d. The determination of a reasonable transition period before new enrollee transfers to a participating provider is made on a case-by-case basis.
    e. As a condition for the member to continue care with the non-participating provider, VHP requires the non-participating provider to enter into an Agreement for Services. The Agreement requires the provider to meet the same contractual terms as its participating providers, including location within the Plan's service area, reimbursement methodologies, and rates of payment.
    f. UM staff in conjunction with VHP Member Services assist members whose benefits have ended to transition to other programs. UM staff and VHP Members Services staff act as resource regarding other benefit programs that may include individual conversion plans, COBRA, and State or Federal funded programs. For all delegated products, VHP will work with the Health Authority to transition care.
    g. UM staff in conjunction with the Associate Medical Director of Behavioral Health coordinates continuity of care with members who are transitioning from a non-VHP behavioral health provider to the VHP network.
17. Referral Management
    The UM Department ensures access to specialist and ancillary appointments within State regulation.
18. Pharmacy Authorization
    a. VHP does not require prior authorization of drugs listed in the approved formulary, unless specified, and dispensed by a Network Pharmacy.
    b. PCPs may request approval for medically necessary non-formulary prescription drugs through the Medically Necessary Non-Formulary Drugs process (see policy PM 2.0).
    c. VHP considers requests for non-formulary drugs on a case-by-case basis.
    d. On a quarterly basis, the formulary is reviewed and updated through the Valley Health Plan Pharmacy and Therapeutics Committee (see policy PM 1.0).

19. Quality Control (QC)
    a. VHP ensures that UM Program
        - Complies with VHP policies and procedures
        - Meets regulatory requirements through a quality control program
        - Achieves the goal of timely access to health care for its covered members through periodic audits and
        - Reviews of the utilization review decision-making process including URCs and medical directors.
    b. The UM Department's QC program does not replace any initiatives developed by the QM Department. The results of the QC reviews and audits are made available to the UMC and QMC.
    c. Program components: The staff is evaluated on their knowledge of the authorization process, applications of review criteria and clinical practice guidelines, documentation practices, and timeliness in decision-making. There are two components of the Quality Control program that accomplish this:
        - *Component One*: Semi-annual reviews of a sample of department work. This review gives management a quick assessment of the department's performance in terms of timeliness and overall authorization processing. The UM Manager randomly samples no less than 20 (15 approvals and 5 modified/denials) authorization requests processed within the past quarter.
        - *Component Two*: At least biannual evaluation of review staff and their UM decisions using screening guidelines; clinical guidelines and protocols; and VHP's medical policies.
    d. The results of the auditing are used to improve UM processes and activities and to correct deficiencies.
20. Fraud and Abuse
    a. The UM staff is aware of the indicators for detecting cases of fraud and abuse (see Anti-Fraud Program). Annual staff training is conducted to review departmental practices and to update staff on any current developments in this area.
    b. The UM Supervisor is responsible for developing quarterly and annual reports to the UM Program Manager.

C. Confidentiality

1. Patient Information
    a. State laws (e.g. H&S Code 56.05 et seq and 5328 WIC) and federal laws (e.g. HIPAA) regulate disclosure or acquisition of medical information by a requestor and, except as otherwise provided, require appropriate authorization by a patient or his/her legal representative.
    b. Protected Health Information (PHI) involving the medical care of members is treated with the highest level of confidentiality to protect both the patient's rights and VHP's legal requirements that include the protection of peer review information.
    c. Member medical records and patient information are kept in locked files and are accessible only to the review staff who are working on the authorization request.
    d. Member medical information in the computer are secured by passwords that limit the access to authorization records to the UM review staff.
2. Confidentiality Statements
   Annually, members of the UM Department and Medical Directors are required to sign a Confidentiality statement. The Confidentiality Agreement is kept on file at the Health Plan offices. (See Attachment B)
3. UMC Meeting Minutes
   All records and proceedings of the UMC are confidential and protected from discovery according to State statute.
4. HIPAA

The UM plan will be in compliance with all pertinent elements of HIPAA. (Using and Disclosing Minimum Necessary Protected Health Information Policy #HHS 585.11 and Verification of Identity and Authorization Policy #585.04)

D. Utilization Data Analysis

1. Data tracked through a variety of mechanisms are reviewed, analyzed, and reported to the UMC, QMC, and the HHC. Utilization data and fraud indicators are reviewed for over and under-utilization, provider practice patterns, and utilization trends. Opportunities for improvement are identified with appropriate improvement action plans. UM data definitions (see Attachment C)
2. The UM Department:
    a. Set measures to identify over and under-utilization for members
    b. Monitors the actual Plan performance against these set measures
    c. Conducts qualitative analyses to determine cause and effect of utilization patterns
    d. Conduct ad hoc studies regarding select utilization patterns or issues with individual or groups of patients.
    e. Monitor efficiency use of community resource

E. Network Review

The UM Program Manager and the UM Supervisor will provide recommendations for network improvement and planning based upon data analysis and feedback from staff. Some indicator areas are as follows:

a. Increased referrals to non SCCHS specialists
b. Access issues that exceed 30-days from routine appointment
c. Geographic problems that increase patient travel time; to over 30-minutes
d. Problems with specific providers with compliance, quality and patient satisfaction
e. Others such as cost-effective and successful outcomes

F. Disputes, Grievances and Independent Medical Review

1. Any services or treatments that are initially modified or denied based on medical necessity can be reviewed through the dispute/grievance process.
    a. A member may request a grievance by contacting VHP by telephone, fax, or online through the plan's website.
    b. A dispute from a physician, provider or hospital must be submitted in writing to VHP. UM participates in dispute/grievances that are based on medical necessity determinations. (See VHP Grievance Policy MS 9.0 and VHP Provider Dispute policy PR 26.0)
2. Members will be informed in writing of the opportunity to request an Independent Medical Review by the Department of Managed Health Care (DMHC) of decisions made to deny, modify, or delay medical services concerning
    a. The medical necessity of a proposed treatment. California Health & Safety Code 1374.30
    b. Experimental or investigational therapies. Title 28 1300.70.4
    c. Denied claims for out of plan emergencies or urgent care. Title 28 1300.74.30
3. Upon receiving the request for a dispute/grievance based on medical necessity, the UM Department will refer the dispute/grievance letter, any new information submitted, and the previous information from which the medical necessity denial was rendered to the Member Services Department or the Provider Relations Department for processing per Member Services Grievance Policy MS 9.0, and Provider Relations PolicyPR 26.0.
4. Medical Review VHP may provide an external independent review process to examine the Plan's coverage decisions regarding experimental or investigational therapies for individual enrollees.

VI. REFERENCES

Cal. Health & Safety Code §1374.3
CCR 28 §1300.70.4 & 1300.74.30HHS 585.04 Verification of Identity and Authorization
HHS 585.11 Using and Disclosing Minimum Necessary Protected Health Information

Senate Bill 853
UM 1.0 Case Management
UM 10.0 Authorization Process Timeline
UM 25.0 Review Criteria and Division Making Process
PM 1.0 Pharmacy and Therapeutics Committee
PM 2.0 Medically Necessary Non-Formulary Drugs

VII. APPROVED/REVISION HISTORY

Original Effective Date:	03/01/03	**Last Reviewed or Revised Date:**	08/2020
Approved By Manager:	Jenny Vu	**Title:**	UM Manager
Manager Signature:	DocuSigned by: Jenny Vu 08D8353A46BE446...Z	**Date:**	2/9/2021
Approved By Department Executive:		**Title:**	CMO
Department Executive Signature:	DocuSigned by: Guez, Ghislaine Y. BA0CD5952272419...	**Date:**	2/10/2021
Committee Reviewed By (if applicable):	☒ UM ☐ P&T ☒ QMC ☐Compliance ☐ _____	**Approved Date:**	
Committee Chair Name			

ATTACHMENT A: Authorization Request

Valley Health Plan

AUTHORIZATION REQUEST

Instructions: This form is required for authorization of services. Please complete all the **unshaded** sections on this form and fax to the Utilization Management Department at Valley Health Plan.

Fax #: 408.885.4875
Phone #: 408.885.4647

Section 1: **Patient Information**

First Name: _____ Last Name: _____

Date of Birth: _____ Sex (check one): ☐ Female ☐ Male

Address: _____

Phone: _____ VMC Medical Record #: _____

Health Plan ID#: _____

Diagnosis: _____ ICD10 Code: _____

Section 2:

Location of Authorization
☐ Inpatient ☐ Outpatient
☐ Other _____

Request Type (Check One)
☐ Emergency ☐ Routine
☐ Urgent ☐ Retro

Program/Line of Business (Check One)
☐ Employer Group Plan ☐ SCFHP Medi-Cal
☐ Covered CA/Individual & Family ☐ SCFHP HK

Requested Provider

Provider Name: _____

Location: _____

Phone: _____ Fax: _____

Services and Provider Requested

Section 3:

Attach supporting documents such as progress notes, consultation notes, operative/radiological reports, and/or prescriptions to avoid delay in processing request

CPT4 or HCPC	Quantity	Length of Need	Specific Services Requested
1.			
Medical Justification for Request			
2.			
Medical Justification for Request			
3.			
Medical Justification for Request			
4.			
Medical Justification for Request			

Section 4

Requesting Provider: _____ MD Signature: _____ Date: _____

***NOTE TO ALL PROVIDERS:** This authorization is valid only if the patient is eligible on the date of service. Please recheck eligibility prior to delivering service (VHP Commericial patients: 408.885.4760 or 1.888.421.8444 – Medi-Cal Managed Care, Healthy Kids & Healthy Families patients: 1.800.260.2055).*

VHP Provider Manual - Authorization Form

CONFIDENTIALITY
AND
CONFORMITY IN THE UTILIZATION MANAGEMENT DECISION PROCESS

As members of the VHP Utilization Management Department involved in overseeing the successful implementation of the Utilization Management Program, we the undersigned recognize that confidentiality is vital to the free, candid, and objective discussions necessary for the effective management of this process. Therefore, we agree to respect and maintain the confidentiality of all telephonic communications, discussions, deliberations, records, and other information generated in connection with the Utilization Management Department activities and we understand that by signing this agreement we are binding ourselves by contract to maintain such confidentiality. We agree that we will not make any voluntary disclosure of such confidential information except to persons authorized to receive such information by prior written consent of VHP and in accordance with VHP's HIPAA Policies and Procedures.

This agreement and obligation of strictest confidence shall survive the termination of my employment in VHP's Utilization Management Department.

Furthermore, I agree that all Utilization Management decisions will include the following:

- UM decision making is based on appropriateness of care and service and existence of coverage;
- The managed care organization does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care;
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

This agreement conforms confidentiality regulations and National Committee for Quality Assurance UM Standard 13.5.1-3.

_____	_____	_____	
Name (printed)	Name (signature)	Title	Date

ATTACHMENT C UM Data Definitions

DATA ELEMENT	DEFINITION	SOURCE	FORMULA
Commercial acute bed days/1000	All days for VMC and OON	MedInsight	
admits, average LOS, and Readmits	including mental health acute, no residential		
	Combine bed days for Mom and Baby		
	Currently not done		
Commercial SNF bed days/1000	Take out SNF Avg LOS, SNF readmits	MedInsight	
Commercial ED visits/1000	All Hospital Eds, no urgent care	MedInsight	
	does not incl OON ED visits that are admitted		
Behavioral Health acute bed days/1000	All days for VMC and OON	MedInsight	
admits, average LOS, and Readmits	fo mental health acute, no residential		
Behavioral Health residential bed days/1000	All days for OON	MedInsight	
admits, average LOS, and Readmits	Alcohol /drug rehab in non acute setting		
MCMC acute bed days/1000	All days for VMC and OON	MedInsight	
admits, average LOS, and Readmits	excluding mental health acute, no residential		
	Bed days for Mom and Baby are combined		
	includes acute rehab		
MCMC SNF bed days/1000	Take out SNF Avg LOS, SNF readmits	MedInsight	
MCMC ED visits/1000	All Hospital Eds, no urgent care	MedInsight	
	no mental health		
	does not incl OON ED visits that are admitted		
COMMERCIAL			
Total Authorizations	UM Department workload-total auths	Valley Express	
Average Turn Around Time	The time between the logged in date to	Valley Express	
	when open, denied, mod, or hold is entered		

% of auths that meet		Valley Express	
TAT performance standard	urgent =24 hours, routine =5 business days		
	retro =30 calendar days,		
Specialty Referrals	All Referrals that go to an MD specialist	Referral Center	
	does not include referrals that go through UM		
Total number of denials	only includes denials not modifications	Valley Express	

% Denied	Is a % of the total completed auths for the	Valley Express	
	the same time period (above figure)		
MEDI-CAL			
Total Authorizations	UM Department workload-total auths	Valley Express	
Average Turn Around Time	The time between the logged in date to		
	when open, denied, mod, or hold is entered		
% of auths that meet			
TAT performance standard	urgent =24 hours, routine =5 business days	Valley Express	
	retro =30 calendar days,		
Specialty Referrals	All Referrals that go to an MD specialist	referral center	
	does not include referrals that go through UM		
Total number of denials	only includes denials not modifications	Valley Express	
% Denied	Is a % of the total completed auths for the	Valley Express	
	the same time period (above figure)		

COMMERCIAL			
GRIEVANCE AND DISPUTES			
Total Member Services grievances	Only decisions made by the UM department	Member Services	
regarding all service denials	that are grieved by a member		
and % Upheld	Total number of grievance committee decisions		
	to uphold the original decision		
	divided by total number of service grievances		
Total Member Services grievances	Only decisions made by the Claims department	Member Services	
regarding all claim denials	that are grieved by a member		
and % Upheld	Total number of grievance committee decisions		
	to uphold the original decision		
	divided by total number of Claims grievances		

Total Provider Service Disputes	Only decisions made by the UM department	Provider Relations	
and % Upheld	that are disputed by a provider		
	Total number of dispute committee decisions		
	to uphold the original decision		
	divided by total number of service disputes		
Total Provider Claims Disputes	Only decisions made by the Claims department	Provider Relations	
and % Upheld	that are disputed by a provider		
	Total number of dispute committee decisions		
	to uphold the original decision		
	divided by total number of Claims disputes		
MEDI-CAL			
GRIEVANCE AND DISPUTES			
Total Member Services grievances	Only decisions made by the UM department	SCFHP Member Services	
regarding all service denials	that are grieved by a member to SCFHP		
and % Upheld	Total number of SCFHP grievance committee		
	decisions to uphold the original decision		
	divided by total number of service grievances		
Total Member Services grievances	Only decisions made by the Claims department	SCFHP Member Services	
regarding all claim denials	that are grieved by a member to SCFHP		
and % Upheld	Total number of SCFHP grievance committee		
	decision to uphold the original decision		
	divided by total number of Claims grievances		

Total Provider Service Disputes	Only decisions made by the UM department	Provider Relations	
and % Upheld	that are disputed by a provider		
	Total number of dispute committee decisions		
	to uphold the original decision		
	divided by total number of service disputes		
Total Provider Claims Disputes	Only decisions made by the Claims department	Provider Relations	
and % upheld	that are disputed by a provider		
	Total number of dispute committee decisions		
	to uphold the original decision		
	divided by total number of Claims disputes		

Santa Clara Family Health Plan™

Enhanced Care Management (ECM)

ECM Denial and Disenrollment Policy and ECM Care Coordinator Guidelines

POLICY

Santa Clara Family Health Plan™

Policy Title:	**ECM Denial and Disenrollment Policy**	**Policy No.:**	QI.33
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	LTSS	**Procedure Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

The purpose of this policy is to define a consistent process and define reasons to deny or disenroll members from the Enhanced Care Management (ECM) benefit.

II. Overview

Enhanced Care Management (ECM) is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals that is community based, interdisciplinary, high touch, and person centered. The goals of ECM are to improve care coordination, integrate services, facilitate community resources, address social determinants of health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services.

If member does not meet ECM program eligibility or a program exclusion has been identified, member is ineligible for ECM services and denied the ECM benefit. Members eligible for ECM are able to decline or terminate ECM services upon initial outreach and engagement, or at any time throughout the duration of their enrollment.

III. ECM Program Exclusions

A. ECM Duplicative Services
   a. Members cannot be enrolled in both ECM and another program that provides the same services as ECM. The Department of Health Care Services (DHCS) has defined approaches to ECM overlaps/duplicative services:
      i. Cannot be enrolled in both ECM and the following program:
         1. Cal MediConnect (CMC)
         2. Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
         3. Program for All-Inclusive Care for the Elderly (PACE)
         4. Mosaic Family Services
         5. Hospice
      ii. Either ECM or the other program
         1. Members can be enrolled in ECM or in the other program but not both at the same time:

a. Multipurpose Senior Services program (MSSP)
b. Assisted Living Waiver (ALW)
c. Home and Community Based Alternatives (HCBA) Waiver
d. HIV/AIDS Waiver
e. HCBS Waiver for Individuals with Developmental Disabilities (DD)
f. Self-Determination Program for Individuals with I/DD
g. Basic Case Management
h. Complex Case Management
i. California Community Transitions (CCT) Money Follows the Person (MFTP)

iii. ECM as a "wrap"
1. Members can be enrolled in both ECM and the other program. SCFHP must ensure non-duplication of services between ECM and the other program
a. California Children's Services (CCS)
b. Genetically Handicapped Person's Program (GHPP)
c. County-based Targeted Case Management (TCM)
d. Specialty Mental Health (SMHS) TCM
e. SMHS Intensive Care Coordination for children (ICC)
f. Drug Medi-Cal Organized Delivery Systems (DMC-ODS)
g. CCS Whole Child Model
h. Community-Based Adult Services (CBAS)
i. Dual Eligible Special Needs Plans (D-SNPs) [from 2023]
j. D-SNP look-alike plans
k. Other Medicare Advantage Plans
l. Medicare FFS
m. AIDS Healthcare Foundation Plans

B. Reasons to Deny or Disenroll Members
a. Does not meet eligibility criteria
i. Members must have certain chronic medical conditions and experiencing complex social factors influencing their health. If current notes/documentation do not show member meets ECM program eligibility, member is denied ECM services.
b. Unsuccessful Engagement
i. If ECM Provider is unable to contact member and/or member is not actively engaged in ECM services, ECM provider may recommend member for disenrollment. Members are considered uncooperative if they meet at least one of the following
1. Member has missed three consecutive appointments with care team within the last 60 days
2. Member has not completed a care plan within 90 days of enrolling in SCFHP ECM
3. Member has not followed care plan
4. Care team could not reach member within 90 days after calling on three different days and times and an alternative outreach method

c. Unsafe Behavior
    i. Members are considered Unsafe if they meet one of the following:
        1. Member displayed disruptive behavior that keeps the ECM Provides from providing ECM services
        2. Member cause the environment in which they receive services to be unsafe for ECM Providers to continue services

d. Well Managed
    i. Members are considered well managed if they meet one of the following:
        1. Member has met all care plan goals and ECM Provider has determined member has no additional goals
        2. Member has met all care plan goals and member has determined they have no additional goals
        3. Member has continued to meet their care plan goals and ECM Provider has determined member is able to self-manage their care needs
        4. Member has continued to meet their care plan goals and member has determined they are able to self-manage with care needs

e. Transition to Lower Level of Care
    i. Members who have been in tier 3 for at least 6 months may be eligible to transition to a lower level of care. To tier down member from ECM services, ECM Provider follow a tier assessment that may consist of the following elements:
        1. Care adherence
        2. Current health status
        3. Medication adherence
        4. Health literacy
        5. Sexual/reproductive health promotion
        6. Mental health
        7. Drug and alcohol use
        8. Housing
        9. Living situation/support systems
        10. Legal
        11. Income/personal finance
        12. Transportation
        13. Nutrition
    ii. SCFHP or the ECM Provider should work to recommend an alternative program that is better suited for the member's needs, if case management services are still needed or requested by the member
    iii. Members are considered ready to transition to a lower level of care if they meet one of the following:
        1. Member has met all care plan goals and ECM Provider or member has determined member has no additional goals
        2. Member has continued to meet their care plan goals and ECM Provider or member has determined member is able to self-manage their care needs

f. Member Request
    i. Member has notified ECM provider they have elected to disenroll and discontinue ECM services

ii. Members who request to discontinue services are not issued a Notice of Action (NOA) denying the member of the ECM benefit

g. Medi-Cal Termed
   i. Member is not actively enrolled in SCFHP Medi-Cal Plan
   ii. Member who termed out of Med-Cal are not issued a NOA

IV. SCFHP Responsibilities

A. SCFHP is responsible for reviewing relevant information pertaining to members who refer into ECM or ECM enrolled members who meet the criteria for disenrollment. When members cannot be provided the ECM benefit and must be denied the ECM benefit, the member undergoes a review process. If it is determined the member cannot receive the ECM benefit, the member is issued a NOA letter
   a. Members who refer into ECM
      i. When a member self-refers into ECM or is referred by a provider for ECM services, member must meet specific eligibility criteria
         1. If member does not meet ECM eligibility criteria or has been identified to meet one of the program exclusions, the member is denied the ECM benefit and is provided a NOA letter
   b. ECM Provider may recommend members for disenrollment
      i. If an ECM provider identifies member meets one of the exclusion criteria or is ready to "graduate" from ECM services, the ECM Provider may recommend the member for disenrollment
      ii. The ECM Providers are required to submit supporting documentation to SCFHP for review
      iii. The member undergoes a review process, in which SCFHP review the submitted documentations and determines if member meets the graduation criteria or meets one of the program exclusions
      iv. If it is determined the member should be disenrolled from the ECM benefit, the member is issued a NOA, which denies the member from continuing the ECM benefit
      v. If SCFHP determines the member should remain enrolled, SCFHP will communicate the determination to the member's ECM provider and ECM provider will continue services
   c. Claims and Encounter Data
      i. Each month, SCFHP IT generates a Member Information File (MIF) to identify new members who may be eligible, as well as members enrolled in ECM who may meet one of the program exclusions
      ii. Enrolled ECM members who are no longer eligible for the ECM benefit are systematically identified and disenrolled from ECM
      iii. Enrolled members who meet one of the exclusions will be processed for disenrollment and issued a NOA

B. Notice of Action Letter
   a. All members that are denied and/or excluded from receiving ECM services undergo a review process by SCFHP
   b. After completing the review process and it is determined member should be denied the ECM benefit or disenrolled from ECM services, then the member is provided a NOA

i. A NOA letter is sent to the member, the member's PCP, and ECM provider, if applicable.

c. Member disenrollment date is documented in all SCFHP applicable systems

C. ECM Provider Responsibilities

a. ECM Providers are required to notify SCFHP of members who may no longer qualify or wish to discontinue from ECM services

b. ECM Providers are required to submit documentation that support recommendation for member disenrollment from ECM

i. Required documentation may include

1. Care plan
2. Recent chart notes
3. Outreach log
4. Alternate program attestation
5. Other materials as applicable

ii. Upon request, SCFHP may request additional documentations to better review the members' case

c. ECM Providers are subject to report disenrollments using SCFHP's ECM Disenrollment Reporting template

d. ECM Providers may recommend a case management program that may better suit the members' needs

e. ECM Providers document member disenrollment date in member's ECM care plan, if applicable

D. Reference

- Department of Health Care Services. (2021). *California Advancing & Innovating Medi-Cal (CalAIM) Enhanced Care Management Policy Guide.* Sacramento, CA: Unknown

E. Approval/Revision History

First Level Approval	Second Level Approval
Signature Lori Andersen, MPA	Signature Laurie Nakahira, MD
Name Director, Long Term Services and Supports (LTSS)	Name Chief Medical Officer (CMO)
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)
1	Original	N/A		

Santa Clara Family Health Plan™

Enhanced Care Management
Care Coordinator Guidelines

Screening for Enhanced Care Management (ECM)

The ECM benefit is eligible to all Medi-Cal members who meet the eligibility criteria and does not have any network restrictions. To be eligible for ECM, members must be enrolled in Medi-Cal with SCFHP, meet the eligibility criteria for one or more of the following ECM Populations of Focus (POF), and does not meet any of the program exclusions.

Populations of Focus (POF)
Populations 1, 2, and 3 available 1/1/2022
☐ **Population #1 | Individuals and Families Experiencing Homelessness** Must meet all of the following criteria: ☐ Experiencing homelessness per U.S. Department of Housing and Urban Development (HUD) definition of Homelessness ☐ An individual or family who lacks adequate nighttime residence; ☐ An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation; ☐ An individual or family living in a shelter; ☐ An individual exiting an institution into homelessness; ☐ An individual or family who will imminently lose housing in next 30 days; ☐ Unaccompanied youth and homeless families and children and youth defined as homeless under other federal statutes; or ☐ Individuals fleeing domestic violence. ☐ AND inability to successfully self-manage at least one complex physical, behavioral or developmental health need*
☐ **Population #2 | Adult High Utilizers** Must meet at least one of the following criteria: ☐ Visited the emergency department 5 or more times within a 6-month period that could have been avoided ☐ AND/OR have 3 or more unplanned hospital and/or short-term skilled nursing facility stays in a 6-month period
☐ **Population #3 | Adult SMI and SUD** Must meet all of the following criteria: ☐ Meet the eligibility criteria for participation in or obtaining services through the County Specialty Mental Health (SMH) System or the Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program. ☐ AND actively experiencing at least one complex social factor influencing their health ☐ lack of access to food ☐ lack of access to stable housing ☐ inability to work or engage in the community ☐ history of Adverse Childhood Experiences (ACEs) ☐ former foster youth ☐ history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors) ☐ Other ☐ AND meet one or more of the following criteria: ☐ Are at high risk for institutionalization, overdose and/or suicide* ☐ Use crisis services, emergency rooms, urgent care or inpatient stays as the sole source of care ☐ Visited the emergency department or was hospitalized 2 or more times due to SMI or SUD in the past 12 months* ☐ Pregnant or post-partum (12 months from delivery)
Populations 4, 5, and 6 available 1/1/2023
☐ **Population #4 | Individuals Transitioning from Incarceration** ☐ Are transitioning from incarceration or transitioned from incarceration within the past 12 months

☐ AND have at least one of the following conditions:
- ☐ Chronic mental illness*
- ☐ Substance Use Disorder (SUD)*
- ☐ Chronic disease*
- ☐ Intellectual or developmental disability*
- ☐ Traumatic Brain Injury (TBI)
- ☐ HIV
- ☐ Pregnancy

☐ **Population #5 | Individuals at Risk for Institutionalization and Eligible for Long-Term Care Services**

☐ Are eligible for Long-Term Care services who, in the absence of services and support, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF)*

Please note: individuals must be able to live safely in the community with wraparound supports

☐ **Population #6 | Nursing Facility Residents Who Want to Transition to the Community**

☐ Nursing facility residents who are strong candidates for successful transition back to the community and have a desire to do so

Population 7 available 7/1/2023

☐ **Population #7 | Children and Youth**

Eligibility criteria pending guidance from DHCS

Criteria with a (*) are further defined in "Population of Focus Diagnosis Codes"

ECM Exclusion and Disenrollment Criteria

A. ECM Duplicative Services
   a. Members cannot be enrolled in both ECM and another program that provides the same services as ECM. The Department of Health Care Services (DHCS) has defined approaches to ECM overlaps/duplicative services:
      i. Cannot be enrolled in both ECM and the following program:
         1. Cal MediConnect (CMC)
         2. Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
         3. Program for All-Inclusive Care for the Elderly (PACE)
         4. Mosaic Family Services
         5. Hospice
      ii. Either ECM or the other program
         1. Members can be enrolled in ECM or in the other program but not both at the same time:
            a. Multipurpose Senior Services program (MSSP)
            b. Assisted Living Waiver (ALW)
            c. Home and Community Based Alternatives (HCBA) Waiver
            d. HIV/AIDS Waiver
            e. HCBS Waiver for Individuals with Developmental Disabilities (DD)
            f. Self-Determination Program for Individuals with I/DD
            g. Basic Case Management
            h. Complex Case Management
            i. California Community Transitions (CCT) Money Follows the Person (MFTP)
      iii. ECM as a "wrap"

1. Members can be enrolled in both ECM and the other program. SCFHP must ensure non-duplication of services between ECM and the other program
    a. California Children's Services (CCS)
    b. Genetically Handicapped Person's Program (GHPP)
    c. County-based Targeted Case Management (TCM)
    d. Specialty Mental Health (SMHS) TCM
    e. SMHS Intensive Care Coordination for children (ICC)
    f. Drug Medi-Cal Organized Delivery Systems (DMC-ODS)
    g. CCS Whole Child Model
    h. Community-Based Adult Services (CBAS)
    i. Dual Eligible Special Needs Plans (D-SNPs) [from 2023]
    j. D-SNP look-alike plans
    k. Other Medicare Advantage Plans
    l. Medicare FFS
    m. AIDS Healthcare Foundation Plans

B. Reasons to Deny or Disenroll Members
    a. Does not meet eligibility criteria
        i. Members must have certain chronic medical conditions and experiencing complex social factors influencing their health. If current notes/documentation do not show member meets ECM program eligibility, member is denied ECM services.
    b. Unsuccessful Engagement
        i. If ECM Provider is unable to contact member and/or member is not actively engaged in ECM services, ECM provider may recommend member for disenrollment. Members are considered uncooperative if they meet at least one of the following
            1. Member has missed three consecutive appointments with care team within the last 60 days
            2. Member has not completed a care plan within 90 days of enrolling in SCFHP ECM
            3. Member has not followed care plan
            4. Care team could not reach member within 90 days after calling on three different days and times and an alternative outreach method
    c. Unsafe Behavior
        i. Members are considered Unsafe if they meet one of the following:
            1. Member displayed disruptive behavior that keeps the ECM Provides from providing ECM services
            2. Member cause the environment in which they receive services to be unsafe for ECM Providers to continue services
    d. Well Managed
        i. Members are considered well managed if they meet one of the following:
            1. Member has met all care plan goals and ECM Provider has determined member has no additional goals
            2. Member has met all care plan goals and member has determined they have no additional goals
            3. Member has continued to meet their care plan goals and ECM Provider has determined member is able to self-manage their care needs

4. Member has continued to meet their care plan goals and member has determined they are able to self-manage with care needs

e. Transition to Lower Level of Care
    i. Members who have been in tier 3 for at least 6 months may be eligible to transition to a lower level of care. To tier down member from ECM services, ECM Provider follow a tier assessment that may consist of the following elements:
        1. Care adherence
        2. Current health status
        3. Medication adherence
        4. Health literacy
        5. Sexual/reproductive health promotion
        6. Mental health
        7. Drug and alcohol use
        8. Housing
        9. Living situation/support systems
        10. Legal
        11. Income/personal finance
        12. Transportation
        13. Nutrition
    ii. SCFHP or the ECM Provider should work to recommend an alternative program that is better suited for the member's needs, if case management services are still needed or requested by the member
    iii. Members are considered ready to transition to a lower level of care if they meet one of the following:
        1. Member has met all care plan goals and ECM Provider or member has determined member has no additional goals
        2. Member has continued to meet their care plan goals and ECM Provider or member has determined member is able to self-manage their care needs

f. Member Request
    i. Member has notified ECM provider they have elected to disenroll and discontinue ECM services
    ii. Members who request to discontinue services are not issued a Notice of Action (NOA) denying the member of the ECM benefit

g. Medi-Cal Termed
    i. Member is not actively enrolled in SCFHP Medi-Cal Plan
    ii. Member who termed out of Med-Cal are not issued a NOA

Santa Clara Family Health Plan™

Membership Report

Membership

Source: iCat (04/01/2022)

Mbr Ct Sum		Cap Month												
LOB	Network Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
CMC		**9,924**	**9,989**	**10,080**	**10,148**	**10,245**	**10,325**	**10,368**	**10,415**	**10,431**	**10,219**	**10,251**	**10,299**	**10,333**
	Santa Clara Family Health Plan	9,924	9,989	10,080	10,148	10,245	10,325	10,368	10,415	10,431	10,219	10,251	10,299	10,333
MC		**269,043**	**271,246**	**272,590**	**274,030**	**275,227**	**276,227**	**277,198**	**278,873**	**280,666**	**284,439**	**285,171**	**286,873**	**288,485**
	ADMIN-MEDI-CAL ONLY				2,088	1,931	1,881	1,992	2,464	2,185	3,833	1,933	2,273	2,830
	ADMIN-MEDICARE PRIMARY	16,094	16,124	16,224	15,925	16,078	16,152	16,240	16,363	16,455	16,502	16,492	16,565	16,542
	KAISER PERMANENTE	31,418	31,885	32,224	32,568	32,864	33,163	33,401	33,651	33,941	34,268	34,482	34,814	35,122
	NEMS							3,445	3,443	3,457	3,452	3,392	3,384	3,381
	PALO ALTO MEDICAL FOUNDATION	7,277	7,338	7,388	7,400	7,378	7,343	7,342	7,356	7,374	7,381	7,385	7,399	7,387
	PHYSICIANS MEDICAL GROUP	45,945	46,224	46,462	46,353	46,561	46,655	42,907	43,165	43,521	43,953	44,472	44,571	44,659
	PREMIER CARE	15,941	15,966	15,981	15,864	15,818	15,805	15,880	15,935	15,975	16,065	16,152	16,211	16,208
	SCFHP DIRECT	17,442	17,510	17,579	17,504	17,592	17,619	17,840	17,915	18,166	18,367	18,508	18,600	18,709
	VHP NETWORK	134,926	136,199	136,732	136,328	137,005	137,609	138,151	138,581	139,592	140,618	142,355	143,056	143,647
Grand Total		**278,967**	**281,235**	**282,670**	**284,178**	**285,472**	**286,552**	**287,566**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**	**298,818**

Santa Clara Family Health Plan™

Over/Under Utilization by Procedure Type/ Standard UM Metrics

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

Membership

Source: iCAT (4/5/2022)

Year-Month	2021-10	2021-11	2021-12	2022-1	2022-2	2022-3
Medi-Cal	277,198	278,873	280,666	284,439	285,171	286,873
Cal MediConnect	10,368	10,415	10,431	10,219	10,251	10,299
Total	**287,566**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**

Inpatient Utilization: Medi-Cal –SPD DOS 4/1/2021 –3/31/2022

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:4/5/2022)(SPD, no Kaiser no SPD Full Dual

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2021-Q2	1,025	16.12	5,011	4.89
2021-Q3	891	14.05	4,749	5.33
2021-Q4	839	13.21	5,104	6.08
2022-Q1	449	7.03	2,524	5.62
Total	3,204	12.59	19,477	5.43

Note: Data are less complete for more recent quarters due submission lag.

Inpatient Utilization: Medi-Cal – Non-SPD DOS 4/1/2021 – 3/31/2022

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:4/5/2022)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2021-Q2	2,751	4.14	11,109	4.04
2021-Q3	2,956	4.37	12,525	4.24
2021-Q4	2,665	3.88	10,935	4.10
2022-Q1	1,528	2.17	6,055	3.96
Total	9,900	3.62	40,624	4.10

Note: Data are less complete for more recent quarters due submission lag.

Inpatient Utilization: Cal MediConnect (CMC)
DOS 4/1/2021 – 3/31/2022

Source: CMC Enrollment & QNXT Claims Data (Run Date:4/5/2022)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2021-Q2	558	18.87	3,055	5.47
2021-Q3	608	20.13	3,862	6.35
2021-Q4	537	17.50	3,237	6.03
2022-Q1	398	13.05	2,711	6.81
Total	2,101	17.37	12,865	6.12

Note: Data are less complete for more recent quarters due submission lag.

Medi-Cal Inpatient Utilization
DOS 4/1/2021 – 3/31/2022

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	3.62	12.59	4.39
ALOS	4.10	5.43	4.43

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Outpatient Utilization: Medi-Cal –SPD DOS 4/1/2021 –3/31/2022

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:4/5/2022)(SPD, no Kaiser no SPD Full Dual

Quarter	Visits	Visits / 1,000 Member Months
2021-Q2	45,668	718.01
2021-Q3	45,363	715.28
2021-Q4	39,642	624.02
2022-Q1	24,794	388.19
Total	155,467	611.06

Note: Data are less complete for more recent quarters due submission lag.

Outpatient Utilization: Medi-Cal – Non-SPD DOS 4/1/2021 – 3/31/2022

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:4/5/2022)

Quarter	Visits	Visits / 1,000 Member Months
2021-Q2	36,455	54.84
2021-Q3	43,106	63.76
2021-Q4	40,509	59.03
2022-Q1	30,786	43.67
Total	150,856	55.22

Note: Data are less complete for more recent quarters due submission lag.

Outpatient Utilization: Cal MediConnect (CMC) DOS 4/1/2021 – 3/31/2022

Source: CMC Enrollment & QNXT Claims Data (Run Date:4/5/2022)

Quarter	Visits	Visits / 1,000 Member Months
2021-Q2	28,880	976.50
2021-Q3	31,979	1058.80
2021-Q4	31,537	1027.87
2022-Q1	24,019	787.53
Total	116,415	962.43

Note: Data are less complete for more recent quarters due submission lag.

Medi-Cal Outpatient Utilization
DOS 4/1/2021 – 3/31/2022

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Visits / 1,000 Member Months	55.22	611.06	102.57

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Inpatient Readmissions: Medi-Cal

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 2020 and YTD 2021 measurement period (Run Date: 03/17/2022)

Year	LOB	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2,3]
2020	MC - All	3,977	380	9.55%
2021	MC - All	4,736	445	9.40%

[1] A lower rate indicates better performance.
[2] Only for members aged 18-64 in Medi-Cal.
[3] Outliers are not included in the rates.

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Cal MediConnect (CMC) Readmission Rates

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 2020 and YTD 2021 measurement period (Run Date: 03/17/2022)

Rate Description	PCR 2020	PCR 2021
Count of Index Hospital Stays	943	1,045
Count of 30-Day Readmissions	99	124
Actual Readmission Rate	10.50%	11.87%

[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.

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

ADHD Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 2020 and YTD 2021 measurement period (Run Date: 03/17/2022)

Measure	NCQA Medicaid 50th Percentile	2020 Rate	2020 SCFHP Percentile Rank	2021 Rate	2021 SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	44.91%	45.26%	50th	39.29%	25th
Continuation & Maintenance Phase	55.96%	49.28%	25th	46.58%	25th
Antidepressant Medication Management					
Acute Phase Treatment	56.66%	64.15%	75th	70.47%	90th
Continuation Phase Treatment	40.28%	50.40%	90th	54.30%	90th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	73.43%	71.43%	10th	75.00%	50th

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Medical Deep Dive Meeting – 04/07/2022

RDT COS	FY22 Activities
All Other (DME, infusion)	DME – RFP for incontinence supplies **Reports to create for Deep Dive:** • Enteral – Went over reporting. Contracted Provider to bill FFS rather than medical claims. Some claims were for enteral formula. Enteral supplies appropriate for medical claim billing. To further review for potential duplicate billing and provider education. • Physician Administered Drugs (In process) - Will work with Director of UM & Pharmacy to complete.
Behavioral Health Treatment	Underutilization of users compared to VHP and KP, however FFS units/users is greater. Looking into members with over 30 hours of BHT treatment and collaborating with UM on internal updates. -Cost has gone up this last year. Consideration of rate negotiation. Review of members with over 100 hours with Medical Director and Director of Case Management. Went over data pertaining to one BHT vendor. This vendor has the majority of members with over 100 hours. Open FWA case. --Dev Screening Impact – Go over specific diagnosis codes
Community-Based Adult Services	Identify additional members as CBAS aims to prevent IP, ED, and LTC. Goal is to have staffing RN to do assessment and authorizations; expected 100% in person in November.
Emergency Room	Continue LANE – Low Acuity Non-Emergent messaging to providers and members. Starting March 2021, Medical FFS ED LANE visit is back to 2019 level. Between April 2020 and Dec. 2020, ED LANE visit was half of 2019 level.
Federally Qualified Health Center (FQHC)	Telehealth continues to be an option, want to increase utilization for Quality Metrics
HCBS Other	Low spend- under 300k per year, want to encourage utilization especially for Transition of Care (TOC)

Hospice	Want to encourage utilization, UM to work with Hospital CM team to offer services to those who meet criteria, currently being done. To look at potential 3rd party vendor -- Members who could potentially be a fit for hospice.
Inpatient Hospital	Focus on readmission since contracting is unlikely to reduce cost/unit – TOC process below.
Lab and Radiology	Expect increase in COVID, lead testing.
Long-Term Care	Likely see reduction or avoidance due to ECM ILOS LTC transition focus
Mental Health Outpatient – Other/Psy	Telehealth option available – Contract approved. Monitoring in place.
Multipurpose Senior Services Program	Mainly therapies, Audiology – SCFHP collaborate with MSSP to provide case management for those members. Now carved out.
Outpatient Medical Professional	Contracting focus on ambulatory care services. Deep Dive codes and cost. A reporting and sorts by procedure code based off of utilization either on a quarterly basis to identify high drivers and research for fraud waste and abuse or review overages or prior authorization. --Did not have a chance to go over during meeting. Will send out sheet to entire group. CCS Project: Identify members to send bulk referrals to CCS to identify if they are on CCS. If not, we will take a deeper dive to confirm so we can refer to CCS to start with case management. They will create the SARs and reduce our overall cost. --Did not have a chance to go over during meeting. Will send out sheet to entire group.
Outpatient Facility	Telehealth continues to be an option, want to increase quality metrics.
Primary Care Physician	Telehealth continues to be an option, no UM focus as this supports good outcome. – Currently an 8 percent increase for the past 12 months.
Transportation	Separate workgroup focus.
Pharmacy	Jan 22 Carve out for MCL, CMC PBM RFP Completed. Medi-Cal Rx: Looking to create MCL Rx dashboard to help with coordination and utilization. Need to look at adherence reporting within Magellan to make sure members are getting their medication. --Did not have a chance to go over during meeting. Will send out sheet to entire group.

First 3 month Magellan data comparing to MedImpact Dec. 21. Magellan is 20% higher in Rx Count, 42% higher in Paid Amount per month.
For Magellan itself, January and February are about same in Rx Count and Paid Amount. March is 10% higher in RxCount and 15% higher in Paid Amount comparing to Jan. or Feb.

For denied claims, February and March are more than 60% lower than January mainly due to DUR reject error.

California Children's Services (CCS) Utilization Review

Department of Health Care Services (DHCS) provided Santa Clara Family Health Plan (SCFHP) a list of diagnosis codes to identify the potential members under age of 21 who are eligible for the CCS program. Below are the subcategory of the disease.

Since the diagnosis codes are very broad, SCFHP found about 45% of the members under age 21 may potentially be eligible for the CCS program in calendar year (CY) 2021. Utilization for these members were filtered to the Rate Development Template (RDT) units, which showed to be higher by 200 units from the previous year. About 800 of the members heavily received behavioral health services in CY21.

Section 41515.2: Infectious Diseases (ICD-10 A00-B99)

Section 41516: Neoplasms (ICD-10 C00-D49)

Section 41516.1: Endocrine, Nutritional, and Metabolic Diseases, and Immune Disorders (ICD-10 E00-E89)

Section 41516.3: Diseases of Blood and Blood-Forming Organs (ICD-10 D50-D89)

Section 41517: Mental Disorders and Mental Retardation (ICD-10 F01-F99)

Section 41517.3: Diseases of the Nervous System (ICD-10 G00-G99)

Section 41517.5: Medical Therapy Program

Section 41517.7: Diseases of the Eye (ICD-10 H00-H59)

Section 41518: Diseases of the Ear and Mastoid (ICD-10 H60-H95)

Section 41518.2: Diseases of the Circulatory System (ICD-10 I00-I99)

Section 41518.3: Diseases of the Respiratory System (ICD-10 J00-J99)

Section 41518.4: Diseases of the Digestive System (ICD-10 K00-K95)

Section 41518.5: Diseases of the Genitourinary System (ICD-10 N00-N99)

Section 41518.6: Diseases of the Skin and Subcutaneous Tissues (ICD-10 L00-L99)

Section 41518.7: Diseases of the Musculoskeletal System and Connective Tissue (ICD-10 M00-M99)

Section 41518.8: Congenital Anomalies (ICD-10 Q00-Q99)

Section 41518.9: Accidents, Poisonings, Violence, and Immunization Reactions (ICD-10 S00-T88)

Perinatal Morbidity and Mortality (ICD-10 P00-P96)

Santa Clara Family Health Plan™

Dashboard Metrics

Cal MediConnect and Medi-Cal Turn-Around Time – Q1 2022

Santa Clara Family Health Plan

CAL MEDICONNECT	JAN	FEB	MAR	Q1 2022
CONCURRENT ORGANIZATION DETERMINATIONS				
# of Concurrent Requests Received	**215**	140	165	**520**
# of Concurrent Review of Authorization Requests (part C) completed within five (5) working of request	**215**	139	164	**518**
% of Concurrent Review of Authorization Requests (part C) completed within five (5) working of request	**100.0%**	**99.3%**	**99.4%**	**99.6%**
PRE-SERVICE ORGANIZATION DETERMINATIONS				
Standard Part C				
# of Standard Pre-Service Prior Authorization Requests Received	677	654	754	**2,085**
# of Standard Pre-Service Prior Authorization Requests (part C) completed within fourteen (14) calendar days	676	651	746	**2,073**
% of Standard Pre-Service Prior Authorization Requests (part C) completed within fourteen (14) calendar days	**99.9%**	**99.5%**	**98.9%**	**99.4%**
Expedited Part C				
# of Expedited Pre-Service Prior Authorization Requests Received	231	243	260	**734**
# of Expedited Pre-Service Prior Authorization Requests (part C) completed within sevety-two (72) hours	230	242	256	**728**
% of Expedited Pre-Service Prior Authorization Requests (part C) completed within seventy-two (72) hours	**99.6%**	**99.6%**	**98.5%**	**99.2%**
POST SERVICE ORGANIZATION DETERMINATIONS				
# of Retrospective Requests Received	68	80	70	**218**
# of Retrospective Requests (part C) completed within thirty (30) calendar days	68	79	70	**217**
% of Retrospective Requests (part C) completed within thirty (30) calendar days	**100.0%**	**98.8%**	**100.0%**	**99.5%**
PART B DRUGS ORGANIZATION DETERMINATIONS				
# of Standard Prior Authorization Requests (part B drugs) Requests Received	16	9	22	**47**
# of Standard Prior Authorization Requests (part B drugs) completed within sevety-two (72) hours of request	16	9	22	**47**
% of Standard Prior Authorization Requests (part B drugs) completed within seventy-two (72) hours of request	**100.0%**	**100.0%**	**100.0%**	**100.0%**
# of Expedited Prior Authorization (part B drugs) Requests Received	10	8	10	**28**
# of Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	10	8	10	**28**
% of Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Santa Clara Family Health Plan

MEDICAL AUTHORIZATIONS	Jan	Feb	Mar	Q1 2022
Concurrent Review				
Total # of Concurrent Requests Resolved	246	180	208	634
# of Concurrent Review of Authorization Requests completed within five (5) working days of request	243	180	205	628
% of Concurrent Review of Authorization Requests completed within five (5) working days of request	**98.8%**	**100.0%**	**98.6%**	**99.1%**
Routine Authorizations				
Total # of Routine Prior Authorization Requests Resolved	1,036	981	1,162	3,179
# of Routine Prior Authorization Requests completed within five (5) working days of request	1,022	965	1,156	3,143
% of Routine Prior Authorization Requests completed within five (5) working days of request	**98.6%**	**98.4%**	**99.5%**	**98.9%**
Expedited Authorizations				
Total # of Expedited Prior Authorization Requests Resolved	157	165	234	556
# of Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	157	164	232	553
% of Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	**100.0%**	**99.4%**	**99.1%**	**99.5%**
Retrospective Review				
Total # of Retrospective Requests Resolved	350	364	392	1,106
# of Retrospective Requests completed within thirty (30) calendar days of request	347	363	391	1,101
% of Retrospective Requests completed within thirty (30) calendar days of request	**99.1%**	**99.7%**	**99.7%**	**99.5%**
Member Notification of UM Decision				
Total # of UM decisions	1,560	1,519	1,793	4,872
# Member Notification of UM decision in writing within two (2) working days of the decision.	1,554	1,505	1,781	4,840
% Member Notification of UM decision in writing within two (2) working days of the decision.	**99.6%**	**99.1%**	**99.3%**	**99.3%**
Provider Notification of UM Decision				
# Provider Notification of UM decision by telephone, facsimile or electronic mail and then in writing within twenty-four (24) hours of making the decision	1,544	1,499	1,773	4,816
% Provider Notification of UM decision by telephone, facsimile or electronic mail and then in writing within twenty-four (24) hours of making the decision	**99.0%**	**98.7%**	**98.9%**	**98.9%**

Santa Clara Family Health Plan™

Cal MediConnect and Medi-Cal Quarterly Referral Tracking

Q1 2022

Referral Tracking Report

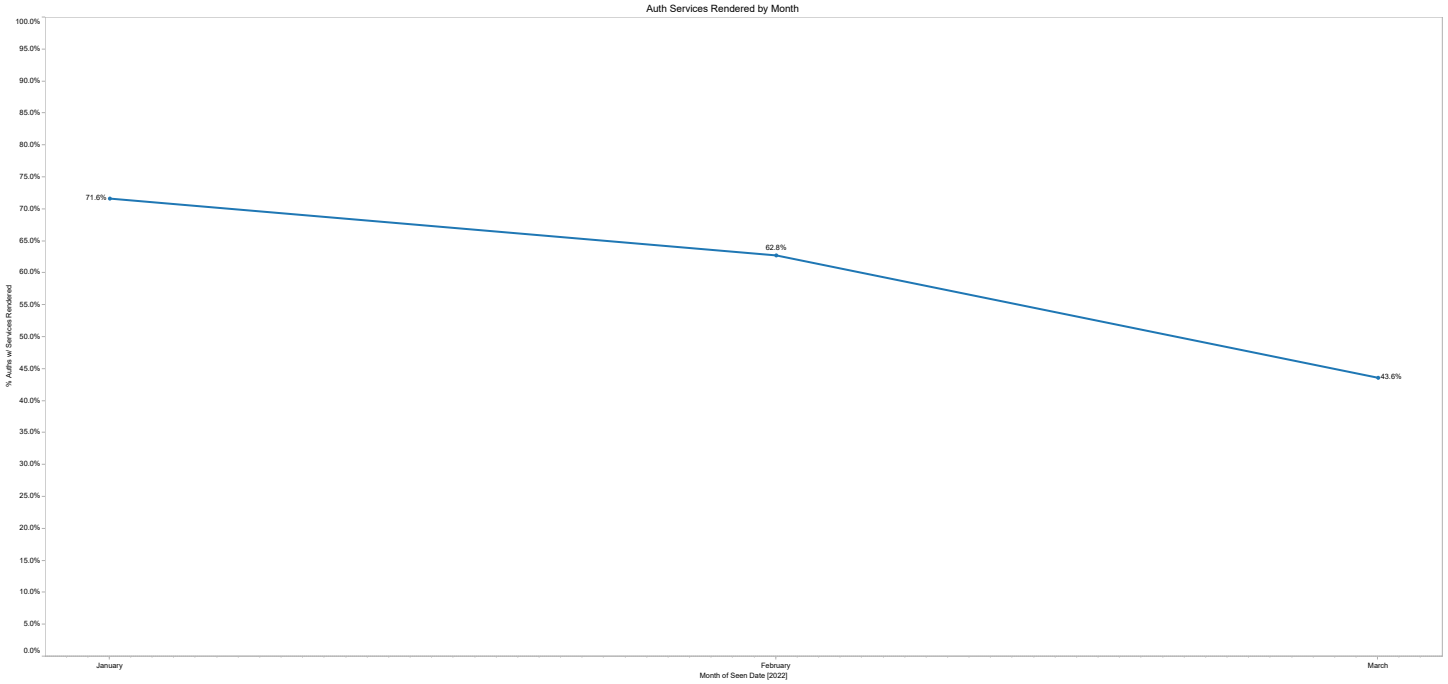
LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	CBAS	Routine - Initial Request	8	7	0	1	12.5%
		Urgent - Extended Service	1	1	0	0	0.0%
	COC DME	Routine - Initial Request	1	1	0	0	0.0%
	CONT OF CARE	CMC Part B Drugs – Routine	1	0	0	1	100.0%
		CMC Part B Drugs – Urgent	1	0	0	1	100.0%
		Member Initiated Org Determi..	1	0	0	1	100.0%
	CONT OF CARE GR	Non Contracted Provider - Urg..	1	0	0	1	100.0%
	CUSTODIAL	Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Routine - Initial Request	37	31	0	6	16.2%
	DME	Care Coordinator Initiated Org..	1	1	0	0	0.0%
		Member Initiated Org Determi..	3	0	0	3	100.0%
		Member Initiated Org Determi..	1	1	0	0	0.0%
		Member Rep Initiated Org Det..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	10	7	0	3	30.0%
		Non Contracted Provider - Urg..	2	1	0	1	50.0%
		Non-contracted CMC Part B D..	1	0	0	1	100.0%
		Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	179	93	0	86	48.0%
		Urgent - Initial Request	16	11	0	5	31.3%
	HomeHealth	Member Initiated Org Determi..	1	0	0	1	100.0%
		Non Contracted Provider - Urg..	2	0	0	2	100.0%
		Routine - Extended Service	19	13	0	6	31.6%
		Routine - Initial Request	36	16	0	20	55.6%
		Urgent - Extended Service	125	52	0	73	58.4%
		Urgent - Initial Request	249	119	0	130	52.2%
	HOSPICE	Non Contracted Provider - Ret..	2	1	0	1	50.0%
	Inpatient	Non Contracted Provider - Ro..	20	19	0	1	5.0%
		Routine - Initial Request	622	616	0	6	1.0%
	InpatientAdmin	Routine - Initial Request	5	4	0	1	20.0%
	InpatientPsych	Routine - Initial Request	4	2	0	2	50.0%
	Inpt Elective	Routine - Initial Request	35	26	0	9	25.7%
		Urgent - Initial Request	38	11	0	27	71.1%
	OP-BehavioralGr	Non Contracted Provider - Ro..	2	1	0	1	50.0%
		Non Contracted Provider - Urg..	1	0	0	1	100.0%
		Routine - Initial Request	1	0	0	1	100.0%
	OP-Behavorial	Non Contracted Provider - Urg..	1	1	0	0	0.0%
		Urgent - Initial Request	1	0	0	1	100.0%
	OPHospital	CMC Part B Drugs – Routine	19	10	0	9	47.4%
		CMC Part B Drugs – Urgent	12	6	0	6	50.0%
		Member Initiated Org Determi..	6	2	0	4	66.7%
		Member Initiated Org Determi..	6	2	0	4	66.7%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	14	4	0	10	71.4%
		Non Contracted Provider - Urg..	6	3	0	3	50.0%
		Non-contracted CMC Part B D..	1	0	0	1	100.0%
		Non-contracted CMC Part B D..	1	1	0	0	0.0%
		Routine - Extended Service	9	5	0	4	44.4%
		Routine - Initial Request	593	161	0	432	72.8%
		Urgent - Initial Request	244	124	0	120	49.2%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	OPHospitalGr	CMC Part B Drugs – Routine	24	10	0	14	58.3%
		CMC Part B Drugs – Urgent	10	4	0	6	60.0%
		Member Initiated Org Determi..	10	5	0	5	50.0%
		Member Initiated Org Determi..	3	1	0	2	66.7%
		Member Rep Initiated Org Det..	4	3	0	1	25.0%
		Member Rep Initiated Org Det..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	5	0	0	5	100.0%
		Non-contracted CMC Part B D..	1	1	0	0	0.0%
		Routine - Extended Service	20	10	0	10	50.0%
		Routine - Initial Request	243	114	0	129	53.1%
		Urgent - Initial Request	58	37	0	21	36.2%
	SkilledNursing	Member Initiated Org Determi..	1	1	0	0	0.0%
		Routine - Initial Request	25	23	0	2	8.0%
		Urgent - Initial Request	48	46	0	2	4.2%
	Transportation	Member Initiated Org Determi..	11	2	0	9	81.8%
		Member Initiated Org Determi..	1	1	0	0	0.0%
		Routine - Initial Request	66	17	0	49	74.2%
Medi-Cal	CBAS	Routine - Extended Service	3	1	0	2	66.7%
		Routine - Initial Request	39	37	0	2	5.1%
	CONT OF CARE	Non Contracted Provider - Ro..	1	1	0	0	0.0%
		Routine - Initial Request	3	0	0	3	100.0%
		Urgent - Initial Request	2	2	0	0	0.0%
	CUSTODIAL	Routine - Initial Request	241	202	0	39	16.2%
	Dental	Routine - Initial Request	27	12	0	15	55.6%
		Urgent - Initial Request	5	2	0	3	60.0%
	DME	Non Contracted Provider - Ret..	6	4	0	2	33.3%
		Non Contracted Provider - Ro..	15	11	0	4	26.7%
		Non Contracted Provider - Urg..	1	0	0	1	100.0%
		Routine - Extended Service	1	1	0	0	0.0%
		Routine - Initial Request	226	104	0	122	54.0%
		Urgent - Initial Request	41	32	0	9	22.0%
	HomeHealth	Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Non Contracted Provider - Urg..	2	0	0	2	100.0%
		Routine - Extended Service	10	1	0	9	90.0%
		Routine - Initial Request	9	4	0	5	55.6%
		Urgent - Extended Service	8	2	0	6	75.0%
		Urgent - Initial Request	16	6	0	10	62.5%
	HOSPICE	Non Contracted Provider - Ret..	13	11	0	2	15.4%
		Non Contracted Provider - Ro..	2	1	0	1	50.0%
		Non Contracted Provider - Urg..	3	2	0	1	33.3%
		Routine - Initial Request	2	1	0	1	50.0%
	Inpatient	Non Contracted Provider - Ret..	3	2	0	1	33.3%
		Non Contracted Provider - Ro..	42	36	0	6	14.3%
		Routine - Extended Service	1	1	0	0	0.0%
		Routine - Initial Request	674	660	0	14	2.1%
	InpatientAdmin	Routine - Initial Request	5	4	0	1	20.0%
	Inpt Elective	Routine - Initial Request	34	23	0	11	32.4%
		Urgent - Initial Request	34	8	0	26	76.5%
	OP-BehavioralGr	Non Contracted Provider - Ret..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	7	2	0	5	71.4%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	OP-BehavioralGr	Routine - Extended Service	59	49	0	10	16.9%
		Routine - Initial Request	29	3	0	26	89.7%
	OP-Behavorial	Non Contracted Provider - Ro..	6	3	0	3	50.0%
		Routine - Extended Service	20	19	0	1	5.0%
		Routine - Initial Request	19	4	0	15	78.9%
		Urgent - Initial Request	1	0	0	1	100.0%
	OPHospital	Non Contracted Provider - Ret..	5	2	0	3	60.0%
		Non Contracted Provider - Ro..	22	4	0	18	81.8%
		Non Contracted Provider - Urg..	10	2	0	8	80.0%
		Routine - Extended Service	40	15	0	25	62.5%
		Routine - Initial Request	448	162	0	286	63.8%
		Urgent - Extended Service	2	0	0	2	100.0%
		Urgent - Initial Request	252	135	0	117	46.4%
	OPHospitalGr	Non Contracted Provider - Ro..	8	6	0	2	25.0%
		Non Contracted Provider - Urg..	5	1	0	4	80.0%
		Routine - Extended Service	84	49	0	35	41.7%
		Routine - Initial Request	403	151	1	251	62.3%
		Urgent - Extended Service	5	3	0	2	40.0%
		Urgent - Initial Request	103	57	0	46	44.7%
	SkilledNursing	Routine - Initial Request	19	18	0	1	5.3%
		Urgent - Initial Request	32	28	0	4	12.5%
	Transportation	Non Contracted Provider - Ret..	65	51	0	14	21.5%
		Routine - Initial Request	411	177	0	234	56.9%
Grand Total			**6,401**	**3,743**	**1**	**2,657**	**41.5%**


Auth Services Rendered by Month
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
% Auths w/ Services Rendered
71.6%
62.8%
43.6%
January
February
March
Month of Seen Date [2022]

Santa Clara Family Health Plan™

Cal MediConnect and Medi-Cal Annual Referral Tracking

2021 Annual Assessment

Cal MediConnect and Medi-Cal Annual Referral Tracking for 2021

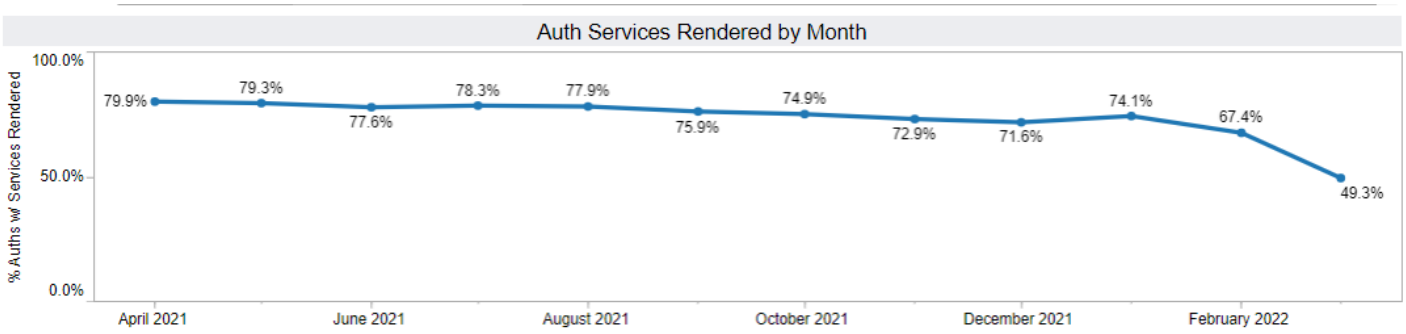
SCFHP tracks all authorizations for the completion of the authorization to claims paid cycle to identify opportunities for improvement. Authorizations are to both contracted and non-contracted providers and include behavioral and non-behavioral health requests. SCFHP has a referral tracking system which tracks approved, modified, and deferred medical and behavioral health prior authorizations (PAs to completion on an ongoing basis.

DATA
Rolling 12 month look back of April 2021 to March 2022.

FINDINGS

1. There were 22,819 unique authorizations for both lines of business (2,558 authorizations per month on average). An increase of 7,880 approved prior authorizations from the previous report. 8,262 (26.9%) of claims did not have a claims match.
    - Cal MediConnect: 3,930 approved PAs without claims
    - Medi-Cal: 4,332 PAs without claims

2. It was identified that there is an average 3 months claim lag time.
    - 73.1% of authorized services were rendered and a claim paid within 90 days of authorization, down about 3% from 76.1% from the 2020 report
    - 1% were rendered and a claim paid after 90 days of authorization.
    - 26.9% did not yet have a claim paid



3. Types of requests, volume, and percentage of authorizations with no claims match:

Category	Volume	Percent
Outpatient Hospital	5,132	22.49%
Transportation	1,010	4.43%
DME	703	3.08%
Home Health	665	2.91%

Inpatient - Elective	202	0.89%
Custodial	174	0.76%
Behavorial Health	182	0.80%
Inpatient	63	0.28%
Dental	43	0.19%
Skilled Nursing	34	0.15%
Hospice	29	0.13%
COC	19	0.08%
CBAS	6	0.03%
Total	**8,286**	26.9%

FOLLOW UP

Authorizations were pulled and a random sampling of 60 unique approved authorizations that did not have claims attached were reviewed, this included 10 for oversampling. Outreach was made to each member by phone to assess why the service was not received or delayed.

1. Sampling:

Category	**Sample Number**
CBAS	5
COC	5
Custodial	7
Dental	6
DME	9
Home Health	5
Hospice	2
Inpatient	4
Inpatient - Elective	2
Outpatient	5
Outpatient Hospital	5
Transportation	5
Total	**60**

2. Results:
    - Only 12 of 60 calls were considered successful.
    - 1 member did not know their authorization by their doctor was approved. 1 member was unsure that their authorization by their doctor was approved.
    - 5 of the 12 members did not receive services.
        - Reasons for not receiving services yet:

        - COVID-19.
        - Too many things going on.
        - Did not know request was approved.
    - 1 member did not provide reason why did not go to receive the approved services.
- 2 members were referred to Case Management.

SUMMARY

Majority of outreaches were unsuccess as there were no answers. All outbound calls had 3 attempts on different days. The main reason for not obtaining service from the limited successful results was COVID-19. The one member that was not aware of the approved authorization was for genetic testing. Based on our outreach, the member followed up to request an extension of the authorization which the plan granted as the member has not received services. Currently, outbound calls to members are only made on urgent authorization requests. There may be opportunity to expand the number of referral tracking sample quanity and frequency to inform members of their approved authorizations. Santa Clara Family Health Plan is committed to working on improving the service delivery systems to our members. The Utilization Management team will continue to track referrals and report findings to the UM Committee.

Santa Clara Family Health Plan™

Quality Monitoring of Plan Authorizations and Denial Letters

(HS.04.01) – Q1 2022

Quality Monitoring of Denial Letters for HS.04.01
1st Quarter 2022

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 quarterly 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 1st quarter of 2022 in order to assess for the following elements.

A. Quality Monitoring

1. The UM Director and Medical Director are 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:
        - Turn-around time for decision making
        - Turn-around time for member notification
        - Turn-around time for provider notification
        - Assessment of the reason for the denial, in clear and concise language
        - 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.
        - Type of denial: medical or administrative
        - Addresses the clinical reasons for the denial
        - Specific to the Cal Medi-Connect membership, the denial notification includes what conditions would need to exist to have the request be approved.
        - Appeal and Grievance rights
        - Member's letter is written in member's preferred language within plan's language threshold.
        - Member's letter includes interpretation services availability
        - Member's letter includes nondiscriminatory notice.
        - Provider notification includes the name and direct phone number of the appropriately licensed professional making the denial decision

III. Analysis

A. For Q1 2022, the dates of service and denials were pulled in April 2022.
   1. 30 unique authorizations were pulled with a random sampling.
      a. 15 Medi-Cal denials and 15 CMC denials.
      b. 7/30 were expedited (urgent) requests.
         - 100% of the expedited authorizations are compliant with regulatory turnaround time of 72 calendar hours
      c. 50% Medical vs. administrative denials.
      d. 100% were denied by a clinical/health services professional:
         - 2 of the 30 cases were denied by a pharmacist instead of a Medical Director for physician administered drugs.
      e. All denials had written notifications to the member.
         - 100% of the letters had the correct threshold language template.
         - 3/30 Chinese, 2/30 Spanish, 1/30 Tagalog, 3/30 Vietnamese, 21/30 English.
      f. 30/30 of the written notifications included the rationale for denial.
      g. 30/30 of the letters included interpreter rights.

B. Opportunities
      a. 23/30 were standard requests
         - 96% of the standard authorizations are compliant with regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB / or 30 calendar days for retro).
         - One CMC case was completed in 15 days rather than 14 days.
      b. 1 of 3 expedited authorizations did not have oral notification to member, however written notification was within the required compliance timeframe.
      c. 29/30 of the written notifications were met readable quality.
         - 1 letter had a run on sentence which made the denial criteria requirements slightly unclear.
         - 4 other letters have opportunity for improvement, but meet readable quality.

IV. Follow-Up

The Utilization Management leadership team and Medical Director will the findings of this audit and recommendations from that finding presented to UMC are as follows:

1. Quality and productivity will continue to be monitored on a regular basis including these quarterly audits. Findings were reviewed by the Medical Director.
2. Identify root cause for late case and identify any opportunities to prevent late cases.
3. Issues will be addressed with the appropriate staff member.
4. Lengthy long term care denial- opportunity to shorten denial verbiage for a concise denial.
5. Reminder to the team to double check for grammar: as one letter was readable, but was missing a parenthesis.
6. Consideration to further define or spell out “autism” and/or “sinus”.
    - Sinus denial has CPT MRI code/description of the brain.

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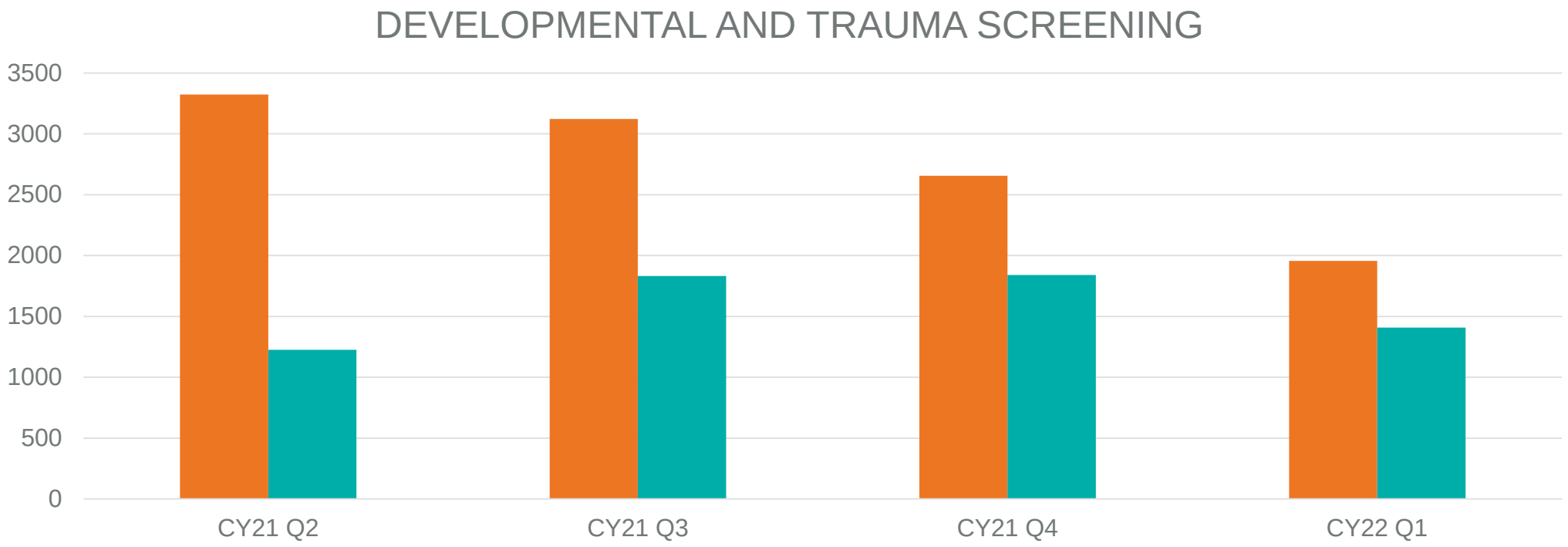
Behavioral Health UM

Behavioral Health

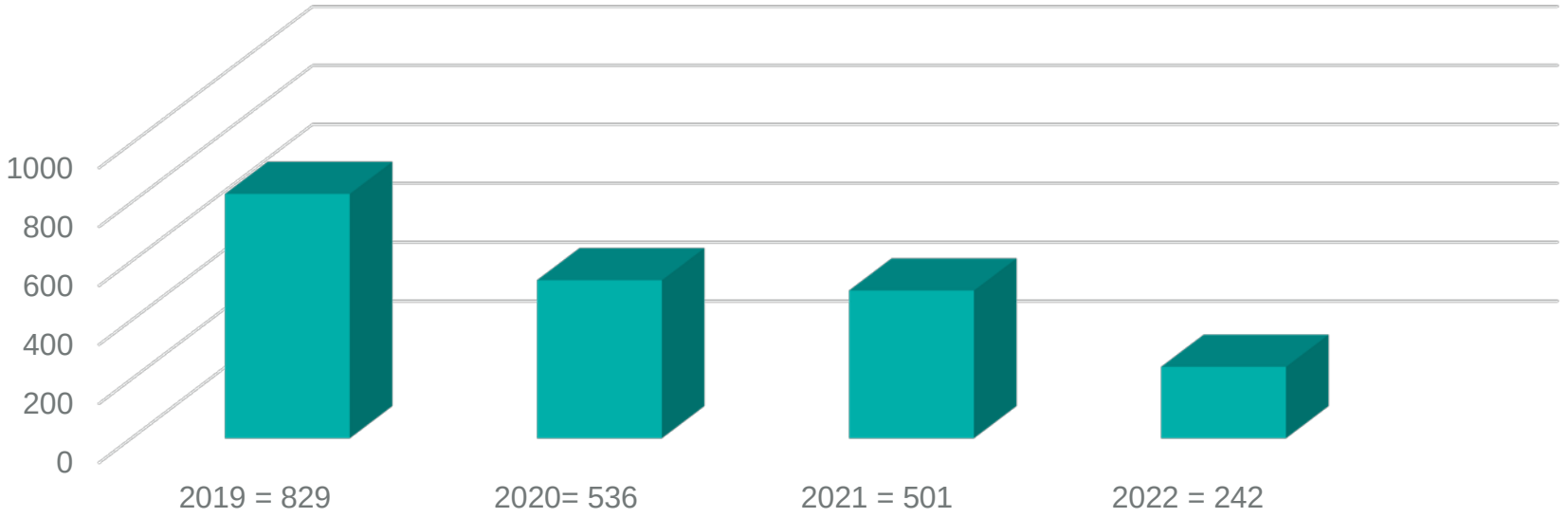


Orange = dev
Teal = trauma

Data pull 4/7/22

Behavioral Health

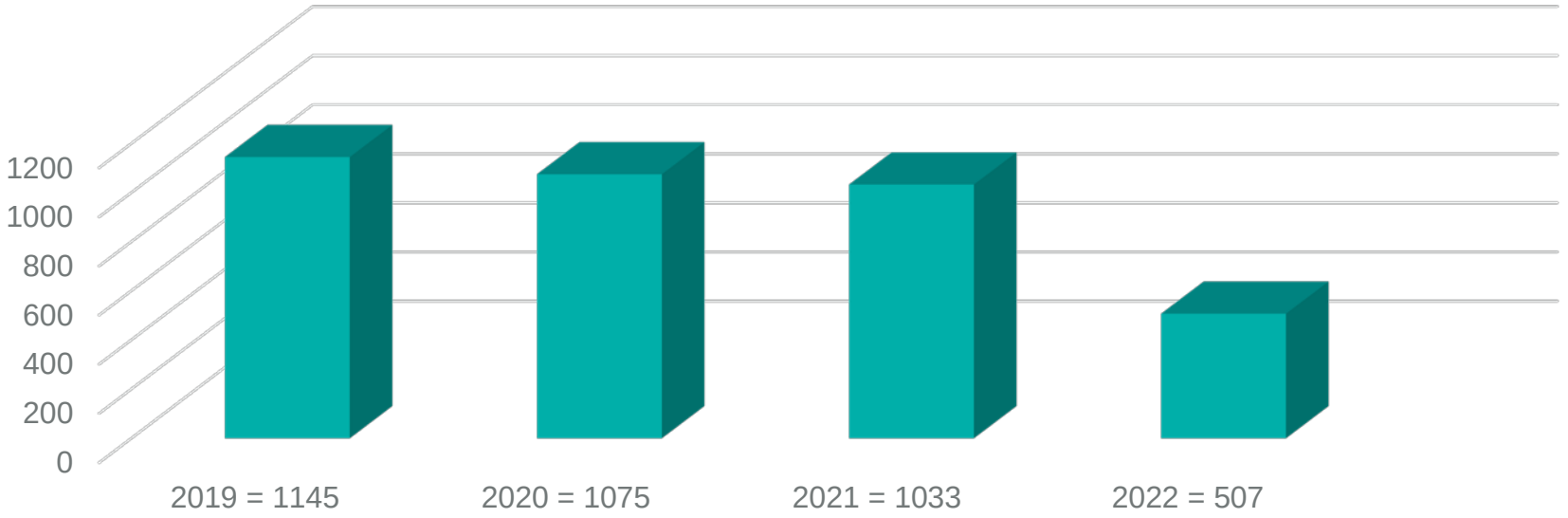
Utilization: Behavioral Health** **Cal MediConnect per 1,000**



Run Date 4/7/22
** Utilization may include both specialty and mild to moderate
Category of Service: Visit, Unique member, Service NPI, Date of service

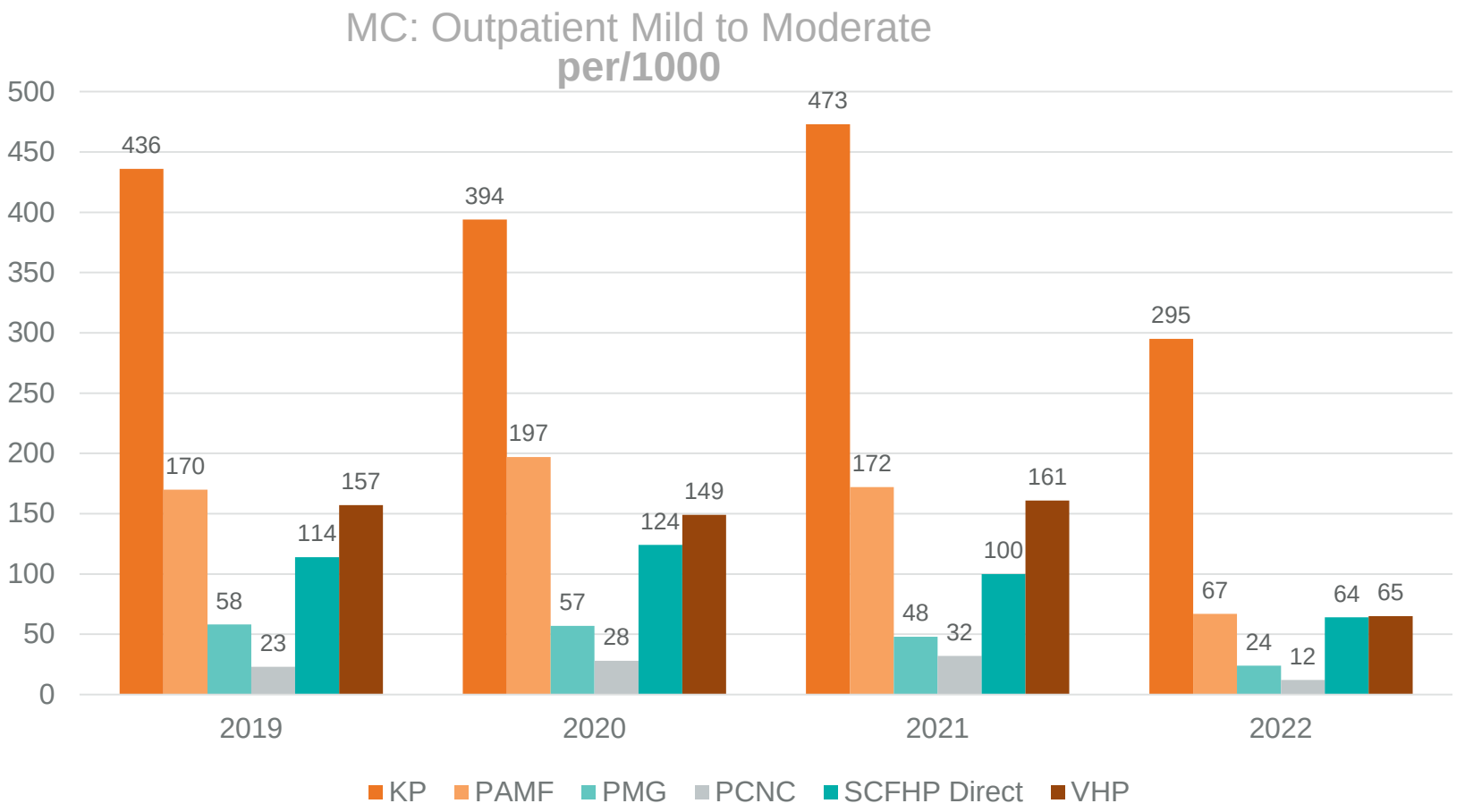
Behavioral Health

Utilization: **Cal MediConnect Unique Members**



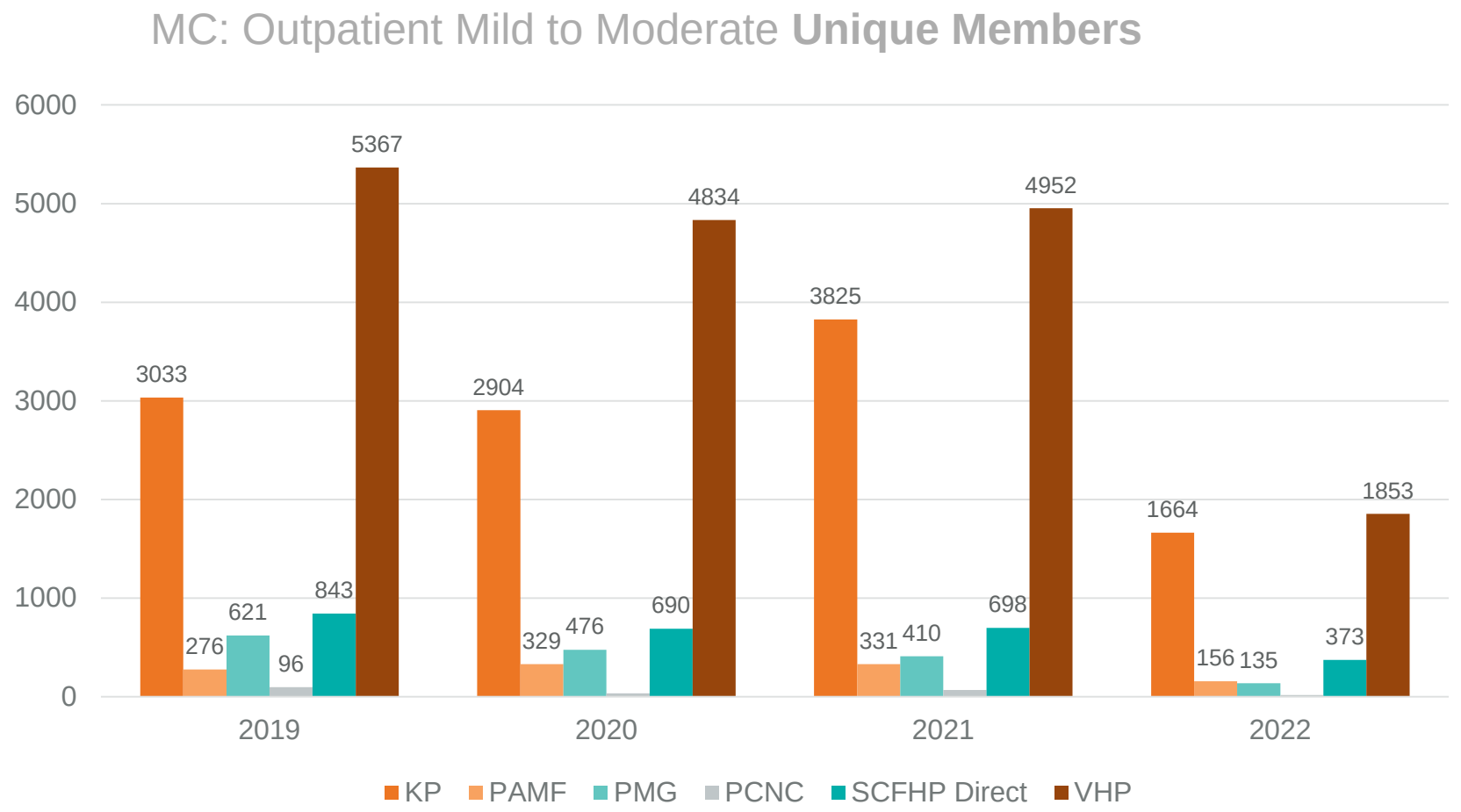
Run Date 4/7/22
Category of Service: Visit, Unique member, Service NPI, Date of service
Outpatient Mental Health = All ages

Behavioral Health



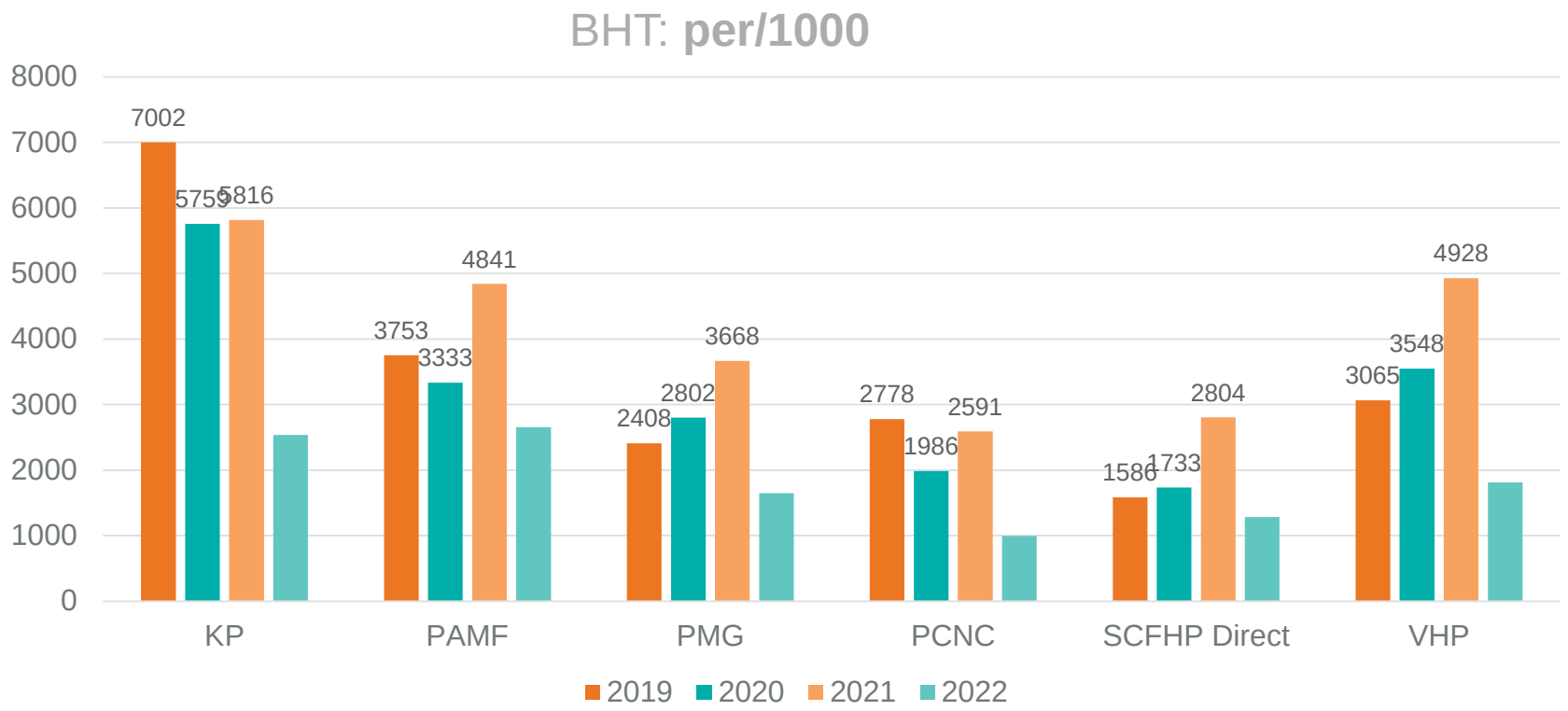
Run Date 4/7/22

Behavioral Health



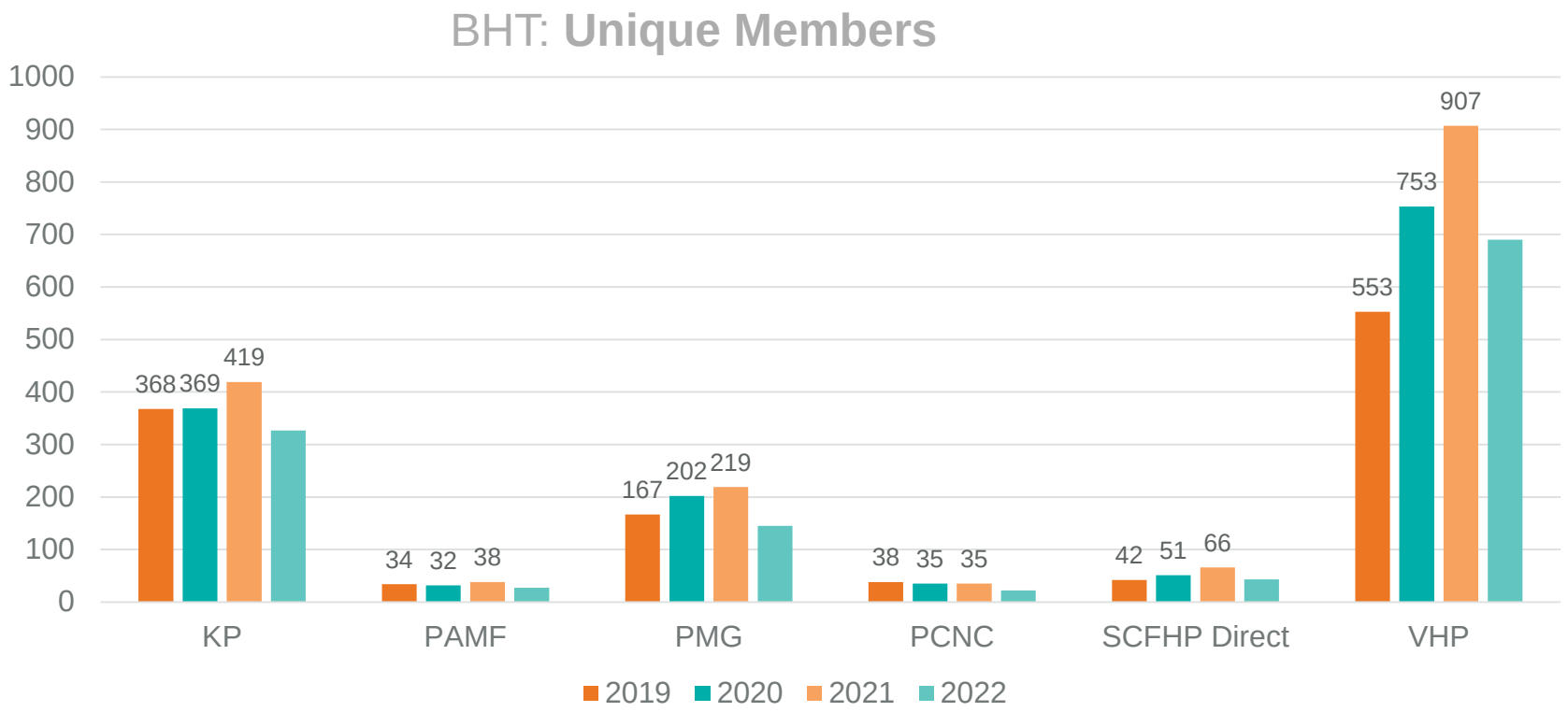
Run Date 4/7/22

Behavioral Health Treatment



Run date 4/7/22
BHT = Units = hours
Member = <21 years

Behavioral Health Treatment



Run date = 4/7/22

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Adjournment