MANAGED CARE COORDINATORS

The Utilization Management (UM) Department has Managed Care Coordinators whose role is to provide utilization information (referrals, prior authorization, benefit determination, etc.), and to serve as principal staff support for medical offices. Telephone calls should be directed to a Managed Care Coordinator as shown below.

The UM department representatives work with physician office staff only. If a patient has a question regarding prior authorization or referrals, please give them the phone number of the Santé Customer Service Department (559) 228-5410. These two departments work closely on patient issues.

UM Department Main Line (559) 228-5430

MANAGED CARE COORDINATOR	TELEPHONE NO.
Allyson Souza	559-228-5470
Sue Vang	559-228-4310
Richard Ramirez	559-228-5415
Rose Casillas	559-228-5449
Joanna Montano	559-228-4354

SANTÉ PHYSICIANS

CASE MANAGEMENT

Contact persons:	Telephone:	Fax:
Harpeet Gill, R.N., Certified Case Manager	559-228-5487	559-224-2405
Ruth Martinez, R.N., Certified Case Manager	559-228-5482	559-224-2405
Harpreet Chahal, R.N. Certified Case Manager	559-228-5405	559-224-2405
Brandelyn Lint, R.N. Certified Case Manager	559-228-5463	559-224-2405

Case Management

The purpose of the Case Management program is to ensure that medically necessary care is delivered in a high-quality, cost-effective setting for members who require extensive or ongoing services. Case Managers coordinate individual services for members whose needs include ongoing medical care, home health, hospice care, rehabilitation services and preventative services. To meet identified member's needs, case managers work with all members of the healthcare team including physician, patient, and family members.

Community Case Management

Community Case Management is a community-based model that assists identified members with healthcare needs. Members of all ages are followed by a specific case manager who plans and coordinates the member's care throughout the healthcare continuum. The Community Case Manager, using a "team approach," acts as a consultant and advocate for members served. The goal is to maintain the member on their wellness path. Members who may benefit include members with:

- Chronic condition/illness
- Chronic/ reoccurring medical problems
- Multiple hospital admissions/ER visits
- Functional or emotional impairment
- Frail elderly
- Poor support system at home
- Potential for complications due to multiple health/social problems.
- High risk pregnancy

Referral to Case Managers

Physicians or physician offices are encouraged to refer patients who fit the description of members requiring case managers. Contact persons are listed above.

REFERRALS – POLICY GUIDELINES

Primary Care Physicians (PCPs) act as managers of their patients' health and are responsible for ensuring that their patients in need of medical care beyond their scope of practice are referred to appropriate Specialist Physicians, designated services or providers. Referral forms are to be used by PCPs when directing patients to these providers. (Note: radiology services do not require a Referral Form. See prior authorization guidelines for some procedures.)

- Note: This policy will not apply in situations where patients are seen on an emergent basis or when utilizing one of the self-referring options.

Referral Process

1. A referral form template is provided to each PCP office to refer Santé HMO members to a specialist. The PCP may use the template provided by Santé or use his/her own referral form. If the PCP opts to use his/her own referral form, the referral form must contain, at a minimum, all information contained in the Santé referral form template. Additionally, specialist offices may not impose a practice specific referral form to replace the approved referral form template.

   - **NOTE: Effective January 1, 2015, within 2 days before the actual date of service, providers *must* confirm that the member's health plan coverage is still in effect.**

2. Complete a referral form in its entirety when referring to an in-plan physician specialist, designated service or provider. (Do not complete a referral form for routine services, such as x-rays or lab work.)
   Specialist Providers must contact the PCP to send the referral for Specialty services/providers

3. Referrals must include dates, diagnoses and diagnosis codes. Specify "Consult Only" if you wish the specialist to consult with you before treating the patient. Otherwise, mark the number of visits you wish to authorize during the 180-day referral period *.
4. Fax or mail a copy of the referral form to the Specialist Provider, as well as a copy to Santé **within two working days**. Santé's mailing address is P.O. Box 792, Fresno, California, 93712. The Fax number is (559) 224-2405.

NOTES:

Please contact Utilization Management for authorization of any non-plan provider. This ensures benefit compliance, use of contracted facilities, and negotiation of rates. DO NOT FILL OUT A REFERRAL FORM to a non-plan provider. This will obligate Santé to pay in full, and the referring physician will be monetarily penalized. (See Authorizations.)

Referrals written after a service has been performed will not be honored. (See Retro-referrals.)

*For BBMC (Mental Health) or Vision Care (Ophthalmology):

- Do not specify individual provider name: refer to BBMC or Vision Care.
- Do not mark the "number of visits" field

A physician or clinician will be assigned appropriately and the patient will be contacted with appointment information.

REFERRALS – POLICY GUIDELINES
*Retro Referrals

Retro Referrals are referrals written after the date of service. The Utilization Management Committee has directed that Retro Referrals will be deemed invalid and claims for these services will be denied. (It should be noted that all denials may be appealed.)

Specialty Physicians should require that each patient they see have a valid referral from the patient's Primary Care Physician at the time they are seen. If the patient is seen on an urgent basis or presents himself/herself without a valid referral, Specialty Physicians should immediately contact the Primary Care Physician to receive a valid referral.

A fax copy of a valid referral is acceptable proof that a referral was issued. When the specialist's office contacts the Primary Care Physician's office, the specialist's office should obtain the name of the person with whom they spoke and the control number of the referral, which the Primary Care Physician's office has committed to send. In a situation where a fax copy is unavailable, the control number of the referral may be submitted with the billing for the service rendered.

The above policy will not apply in situations where patients are seen on an emergent basis, or when utilizing one of the self-referring policies in a plan provider's office.

REFERRALS – POLICY GUIDELINES
*Global Care Referrals

A Primary Care Physician may refer to a specialist for "global" care, effective for six months care (or as specified below) without limitations on number of visits allowed, for ONLY the following types of care:

NOTE: See self-referral section for patient options.

1. "Global Oncology," to a hematologist/oncologist or a radiologist/oncologist ONLY for ongoing chemotherapy or radiation therapy for malignancy.

2. "Global Allergy Treatment," to an allergist ONLY for allergy immunotherapy or desensitization by injection.

3. Dialysis.

4. "Obesity Management Program," to a weight management specialist ONLY (see page 703.1). Please include ICD9 code 278.01 on all referrals to this program.

5. "HIV/AIDS", to a HIV/AIDS specialist.

In this case, the PCP should leave the number of visits on the referral blank and specify the type of care and the diagnosis. However, the specialist must communicate with the Primary Care Physician, and the PCP must concur with the treatment plan.

If the Primary Care Physician wishes the number of visits to be limited, he/she must indicate the number of visits desired.

REFERRALS – POLICY GUIDELINES
*Routine Eye Examination Policy

When they are a benefit of the members' health plan, routine eye examinations will only be available from SP Ophthalmologists. If a non-contracted ophthalmologist provides routine eye examinations without prior authorization from Santé, no payments will be made.

Note: See self-referral section for patient options.

The following procedure will cover capitated HMO members of SP.

Process for Routine Eye Examinations:

Health plans are responsible for making members aware of eye care coverage, including benefits (such as examinations) that are not covered.

If a member does have the routine eye examination benefit, the member - not the PCP - is responsible for calling and scheduling the examination with a SP Ophthalmologist; no PCP referral is required.

If pathology is discovered during a routine eye examination, the SP Ophthalmologist will notify the member's PCP in writing. This notification will include a description of the pathology discovered and request a referral for on-going therapy. The SP Ophthalmologist will also keep the member's Primary Care Physician informed of the member's response to treatment and will inform the PCP when the course of therapy is completed.

If the SP Ophthalmologist determines the member to be ineligible for routine eye exam, the member must be informed. If the member agrees in writing prior to routine eye examination being performed, the SP Ophthalmologist may bill the member for the service provided.

If a secondary referral to a non-SP provider is required, the SP Ophthalmologist will inform the member's PCP of the necessity and ask the member's PCP to obtain authorization for the services.

REFERRALS – POLICY GUIDELINES
*Unauthorized Referrals to Non-Plan Providers

Non-authorized elective services rendered by a non-plan provider, as a result of a Santé contracted physician referral, shall be approved for payment according to the following protocol:

- Services will be paid to the non-plan provider at 100% of billed charges.
- The referring Santé physician's future reimbursements will be debited the amount equal to the difference between payment made to the non-plan provider and the Santé contract reimbursement rate, not to exceed $1000 for each unauthorized referral.

Note: Self-referral option is the only exception.

REFERRALS – POLICY GUIDELINES
*Self-referrals – Specific HMO Plans

The following HMO plans provide limited self-referrals to specialist providers without the use of the Santé referral form:

1. **Blue Shield**
   All Blue Shield HMO members may participate in the ***Blue Shield Access +*** enhancement. This enhancement allows the patient to self-refer to a Santé Specialist Physician or PCP, other than assigned PCP.

   - Services included
     - Basic examinations/consultations/routine office based diagnostic and/or treatment procedures performed during the Access + visit
     - Conventional x-rays (excluding diagnostic imaging, MRI, CT or bone density measurement) and laboratory services that may be provided in the physician's office or by Santé contracted radiology or lab providers
   - $30 copay is collected
   - Send these claims to Santé, indicating Access + Benefit in field #19 on the HCFA 1500 form
   - Patient must present both the Blue Shield HMO ID Card and the Access+ Specialist Card

2. **Blue Cross CaliforniaCare**
   All CaliforniaCare HMO Members may participate in the ***Direct Access*** enhancement. This enhancement allows the patient to self-refer to a Santé Specialist Physician in the following areas only:
     - Allergy
     - Dermatology
     - Ear, Nose & Throat
     - Obstetrics/Gynecology

   - Services included
     - Medically necessary services that can be done in the Specialist's Office. Any care needed outside the Specialist's office must be coordinated through the PCP
   - Normal copay is collected
   - Number of visits are not limited
   - Send these claims to Santé, indicating Direct Access in field #19 on the HCFA 1500 form
     - No changes on CaliforniaCare ID Card
     - CaliforniaCare POS plans offer this enhancement as well

REFERRALS – POLICY GUIDELINES
*Self-referrals – OB/GYN

An HMO female member has the option of seeking obstetrical and gynecological physician services directly from a Santé OB/GYN or from a participating family practice physician, surgeon, or internist designated as providing OB/GYN services. Additionally, self-referral patient information must be communicated back to the patient's PCP of record. This includes:

- OB/GYN preventive care
- Pregnancy
- Gynecological complaint

OB/GYNs and other specialists treating a Santé HMO patient under this policy must remember to mark SELF-REFERRAL in box 19 of your HCFA form in lieu of submitting a Santé referral number and form.

REFERRALS – POLICY GUIDELINES
*Behavioral Health Referrals

Blue Cross, Blue Shield, Cigna, Health Net
Due to Assembly Bill 88, these plans have chosen to "carve out" behavioral health benefits and utilize a "carve-out administrator" as listed below.

A referral from the Primary Care Physician is not necessary for members to access services. The provider office can direct the member to contact the behavioral health administrators at the following numbers:
(Please keep in mind that the PCP may also contact the administrator)

Aetna (Commercial) Contact "Aetna Member Services" number listed on the Back of patient ID card and request assistance with a behavioral health referral

Blue Cross (Commercial & Senior)
Behavioral Health Plan 1-800-677-6669

Blue Shield (Commercial)
Magellan 1-877-263-9952

Cigna Check Member ID Card – Carve out providers vary

Wellcare/Easy Choice
Value options 1-855-278-2095

Health Net (Commercial & Medicare)
Managed Health Network For urgent or emergent referrals: 888-426-0030
Self-referrals: call phone number on back of ID card

Santé Mental Health Providers, Bio-Behavioral Medical Clinic, Inc. (BBMC), have contracts with the HMO Behavioral Health Companies and can be requested as providers. See "Specialist Roster" for listing.

REFERRALS – POLICY GUIDELINES
*Behavioral Health Referrals (continued)

UnitedHealthcare (Formerly PacifiCare)
UnitedHealthcare members have “core services” of 20 crisis intervention services. For these “core services” send a Santé referral form to Bio-Behavioral Medical Clinic, Inc. (BBMC) to access care.

UnitedHealthcare members who have a “*severe mental illness” (listed below), contact US Behavioral Health Plan California (USBHPC) at: (800) 999-9585 for mental health benefits:

***SEVERE MENTAL ILLNESS (Parity Diagnoses):**

- schizophrenia
- schizophrenia disorder
- bipolar disorders
- manic-depression
- major depressive disorders
- obsessive-compulsive disorders
- panic disorders
- autism
- anorexia or bulimia
- serious emotional disturbance of a child

UHC Commercial HMO Members (Health Plan Risk)
Access mental health services through Optum Behavioral Health at 800-999-9585.

UnitedHealthCare Medicare Solutions: Group Retiree/AARP Medicare Complete (Formerly Secure Horizons)
All behavioral health benefits for UnitedHealthCare members are administered through Bio-Behavioral Medical Clinic, Inc. (BBMC). Send a Santé referral form to BBMC to access care.

Community Care Health (CCH)
All behavioral health benefits for Community Care Health Plan members are administered through Bio-Behavioral Medical Clinic, Inc. (BBMC). Send a Santé referral form to BBMC to access care.

PRIOR AUTHORIZATION
* Guidelines

Selected services require prior authorization in order to:

- ensure benefit compliance, use of contracted providers and review of medical necessity;
- provide timely involvement of HMO corporate resources;
- allow contracting of rates when using non-plan providers.

Please request services as soon as ordered by the physician in order to allow adequate time for the authorization process. All routine authorizations should be submitted by fax. *See sample and master fax form.*

Do not schedule appointments prior to authorization approval. Elective services must be requested a minimum of 48 hours or two full working days prior to scheduled service. If the requesting physician determines that the patient's medical condition requires emergent medical service, the provider must ensure the patient receives timely service and then proceed with the authorization process. However, should review of the information determine that the service was not medically indicated and authorization would not have been given, the service will be denied and the contracted provider(s) must write off all services.

Please note that, from time to time, the Santé Utilization Management Committee will require prior authorization for services other than those listed on the Prior Authorization Form. Pre-authorization requirements may vary by provider or specialty. The Santé Utilization Management Committee will notify you of these requirements.

Prior Authorization Fax Number
559-224-2405 or 559-224-9746

Prior Authorization Not Obtained
Claims for non-emergent services that require prior authorization which are rendered by contracted providers without prior authorization will be denied. Such services will not be the liability of the member. These determinations are subject to appeal.

PRIOR AUTHORIZATION
* Guidelines (continued)

Guidelines for
Aetna, Aetna Medicare Advantage Plan, Blue Shield Access +, Blue Shield 65+, CaliforniaCare, Cigna, Health Net, Health Net Healthy Heart, Health Net Amber II, UnitedHealthcare (Formerly PacifiCare/Secure Horizons)

Services Requiring Prior Authorization

- Aqua Therapy
- Breastfeeding Medicine Referral
- Balance & Dizziness Referral
- Colonoscopy; EGD
- Cosmetic/Reconstructive Surgery
- Durable Medical Equipment purchases over $200 (Per line item)
- Durable Medical Equipment (All rentals, regardless of cost)
- Endocrinologist Visit (Type II Diabetes)
- Home Health / Home IV
- Infusions – Ambulatory
- Injections: Self–injectables; in-office injectables listed on back of authorization form
- M2A Video Capsule Endoscopy
- MRI, MRA, CT and Pet scans
- Nutrition Consult for Chronic Disease (CMC)
- Obesity – Referral to General Surgeon
- Obesity Surgery
- Out of Plan Provider
- Plastic Surgery Referral
- Sleep Studies
- Transplants (In conjunction with Health Plan programs)
- Weight Management Program Referral
- Wound Care – Facility Based

NOTE: *Emergency services never require prior authorization and will be reviewed retrospectively.*

SANTÉ PHYSICIANS

PRIOR AUTHORIZATION
* Emergency Room Authorization

When possible, HMO members should call their Primary Care Physician for urgent care needs or before seeking emergency services. The Primary Care Physician may refer the member to his/her office, another PCP, an in-plan specialist, or to a Santé contracted emergency room facility, as the situation requires.

Medically necessary emergency services cannot be denied for lack of authorization. Services are to be considered an emergency if; "…in the judgment of any prudent layperson the absence of immediate medical attention could reasonably be expected to result in one of the following, placing the patient's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any body, organ or part."

GENERAL CRITERIA	
Time of Day (in conjunction with condition severity)	• Before 0800, or after 1700 weekdays • Services during standard working hours, if PCP referral • Week-end or holidays
Condition	• Acute (<6 hours), Sudden (<24 hours), severe onset • Condition or symptoms are life-threatening or have significant potential for chronic disability; i.e., a reasonable person would believe it was life-threatening or disabling • Symptoms developed during non-office hours, despite duration (e.g., over weekend/holiday time), and patient has not been seen within the past 12 months for this same diagnosis or condition
L&D Checks	• Approved

PRIOR AUTHORIZATION
* Emergency Room Authorization (continued)

Examples of non-emergent conditions more appropriately treated in office or Urgent Care (unless associated with unstable vital signs or physical findings as above):

- Allergic reactions without dyspnea
- Animal bites that do not require suturing
- Asthma responding to single inhalation or parenteral treatment
- Back pain without recent acute trauma or associated recent neurological complaints or findings
- Bronchitis
- Checks and rechecks of burns, casts, test results or wounds
- Colds or cold sores
- Conjunctivitis without presence of contact lens, foreign body or trauma
- Cough
- Dermatitis, itching, rash
- Diarrhea without bleeding or dehydration in older children and adults
- Dressing change
- Extremity injury without deformity or injury (might be appropriate for urgent care if level of pain requires rule-out fracture)
- Flu symptoms
- Foley catheter replacement
- Genital discharge or pain without abdominal pain
- Headache unless sudden onset, unprecedented severity or associated with fever or recent trauma
- Human bites without tissue disruption
- Ingrown toenails
- Insect bites with only local symptoms
- Lacerations that do not involve nerves or tendons, do not require suturing or are more than 24 hours old
- Localized infections
- Medications administration or refills
- Musculoskeletal pain not associated with recent trauma
- Needle sticks or puncture wounds
- Otitis media unless associated with a temp>103 or ear drainage
- Routine administration of parenteral medications
- Paronychia
- Sinusitis
- Sore throat
- Stye
- Suture removal
- Toothache without facial swelling or lymphadenopathy
- Urinary burning, frequency or infection

PRIOR AUTHORIZATION
* Hospital Observation Status

Patients who have been evaluated either in a physician's office or in an emergency room and found to be too ill to be sent home should be admitted to the hospital and not listed on observation status.

Santé Physicians has established the following policy:

> *Patients admitted directly to the hospital will always be listed under ADMIT status. Patients considered to be unstable for discharge but observed outside the emergency room will be admitted as inpatients and NOT listed on observation status.*

PRIOR AUTHORIZATION
* Criteria used to authorize, modify or deny

When a prior authorization request is authorized, modify, or denied a copy of guideline, protocol or other similar criteria on which the decision was based, can be requested, by calling Santé Physicians at (559) 228-5410 or at the following Health Plans websites:

Aetna
https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html

Anthem Blue Cross
https://www.anthem.com/wps/portal/ca/culdesac?content_path=provider/f1/s0/t0/pw_a111722.htm&rootLevel=0&name=onlinepolicies&label=Overview

Blue Shield
https://www.blueshieldca.com/provider/authorizations/clinical-policies/medical-procedures/policy.sp

Brand New Day
https://bndhmo.com/members/utilization-management/

Cigna
https://cignaforhcp.cigna.com/web/public/resourcesGuest/!ut/p/z1/hU_BTsJAFPwWDj3St5WWNt6IiRRCkKRR6F7MtjyXZ9rdZndp0a93UU9E8N1mMjNvBjjsgCvRkxSOtBKNxyWfvj7Ns2mUFyyfLzePbLFhD4uoKCYsY7D9FrArN2PAb_tfgAOnqg1J9VDeJXEWx0maRpP0N_qGI9_-vAQuG139rJipapJJ4Abf0KAJj8bTB-c6ex-wgA3DEGJPtTYY1roNWE1SCXmkPTak0P4VcdDWwe7C6Vvz_4qtc90ilH5een1eAtuecIDinOdfQhkwSw6t73aou4AZtPpoalxRZYT58LTu0QiJG91QTWchqT2ews5z55B30QuPtHENuIBYKCPo2ud2vPtc4XashtM6kbPR6AsCVzpn/dz/d5/L2dBISEvZ0FBIS9nQSEh/#Z7_OG861HS0HGJPF0IP0CI1SS3085

Health Net
https://www.healthnet.com/portal/provider/content/iwc/provider/unprotected/working_with_HN/content/medical_policies.action

United Healthcare
https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-medical-drug-policies.html?rfid=UHCOContRD

APPEALS - CLINICAL

When a prior authorization request is denied, the physicians or members have the opportunity to appeal the decision. This form of denial is known as prospective denial, one that is given prior to service rendered.

UM appeals must address the reason given for denial for services requested.

Common UM Denials

1. Cosmetic
2. Not a plan benefit
3. Inadequate medical justification
4. Services can be provided by an in-plan provider
5. Alternate service recommended
6. Does not comply with UM guidelines

Submission of HMO Appeals

For all HMO plans (Commercial and Senior) providers or members are to contact the HMO corporate office directly to submit an appeal. Use the mailing address or telephone number listed in the body of the Santé denial letter. Be sure to include additional information for authorization reconsideration.

To request an appeal by telephone or in writing contact the Health Plan at the following locations:

Aetna Health of California, Inc.
Attn: Regional Medical Services
Commercial Grievance & Appeals Unit
P.O. Box 10169
Van Nuys, CA 91410
Telephone: 1-800-756-7039
Fax: 1-860-754-5321
Internet: www.aetna.com

Aetna Senior
Medicare Plan Grievance & Appeals Unit
P.O. Box 14067
Lexington, KY 40512
Toll Free: 1-800-932-2159
Fax: 1-909-476-5216 or 1-866-604-7092
Internet: www.aetna.com

Anthem Blue Cross
Attn: Grievance & Appeals Department
P.O. Box 4310
Woodland Hills, CA 91365-4310
Telephone: 1-800-365-0609
Fax: 1-818-234-1089
Internet: www.bluecrossca.com

Blue Shield of California
Attn: Member Appeals and Grievances
P.O. Box 5588
El Dorado Hills, CA 95762-0011
Telephone: 1-800-424-6521
Fax: 1-916-350-7585
Internet: www.mylifepath.com

Blue Shield 65 Plus HMO
Appeals & Grievances Department
P.O. Box 927
Woodland Hills, CA 91365-9856
Telephone: 1-800-776-4466
Fax: 1-916-350-6510
Internet:

Brand New Day
Appeal and Grievance Dept.
5455 Garden Grove Blvd., 5th Floor
Westminster, CA 92683
Telephone: 1-866-255-4795
Fax: 1-657-400-1217
TTY/TDD: 1-866-321-5955

CIGNA Health Care
National Appeals Unit
P.O. Box 5225
Scranton, PA 18505-5225
Telephone: 1-800-244-6224
Fax: 1-800-988-4741
Internet: www.cigna.com

Health Net of California, Inc.
Medicare Appeals & Grievances
P.O. Box 10344
Van Nuys, CA 91410-0344
Phone: 1-800-275-4737
Fax: 1-877-713-6189

Community Care Health (CCH)
Appeal and Grievance
P.O. Box 45020
Fresno, CA 93718
Telephone: 1-855-343-2247
Fax: 559-228-5460
TTY/TDD: 1-800-735-2929

UnitedHealthcare
Appeals & Grievances Dept.
Mail Stop CA 124-0157
P.O. Box 6106
P.O. Box 6106
Cypress, CA 90630
Telephone: 1-800-228-2144
Fax: 1-888-517-7113
Internet: www.unitedhealthcare.com