Utilization Management Department/Medi-Cal

Utilization management is the use of managed care techniques such as prior authorizations that allow health insurance companies to manage the cost of health care benefits by assessing its appropriateness before it is provided using evidence-based criteria or guidelines. Santé UM Department consists of Authorization Coordinators, Nurses and Doctors.

Authorizations should be submitted using the Quick Cap Provider Portal. In addition, authorization information or status inquiries can be obtained using the Provider Portal. The portal can be accessed using the following link:

https://www.santephysicians.com/ Portal Issues can be reported to portalsupport@santehealth.net

Services Requiring Prior Authorization

- Bariatric Surgery
- Colonoscopy; EGD; Manometry
- Cosmetic/Reconstructive Surgery
- Durable Medical Equipment purchases over $500 (Per line item)
- Durable Medical Equipment (All rentals, regardless of cost)
- Genetic Testing
- Home Health
- Home Infusion
- Infusions – Ambulatory
- Injections: Self–injectables
- Injections: In-office injectables
- MRI, MRA, CT and Pet scans
- Out of Plan Provider
- Sleep Studies
- Transplants (In conjunction with Health Plan programs)
- Varicose Vein Treatment
- Wound Care – Facility Based

UM Department Turn-around Times

- **Routine requests** – when received with all required documentation, a routine request will be decided **within 5 business days**.
- **Expedited requests** – when received with all required documentation, an expedited request may be decided **as soon as 24 hours and no later than 72 hours**.

An expedited request should only be submitted in situations that are considered time sensitive. A time sensitive situation is defined as any situation in which waiting for the standard decision making process could result in seriously jeopardizing the member's life, health, or the ability to regain maximum function. Examples of time sensitive situations include but are not limited to severe pain and potential loss of life, limb, or major bodily function. **Scheduling matters are not reason for urgent submission.**

The following are situations & conditions where the above urgent criterion does not apply:

- Elective procedures
- DME for pre-existing conditions
- Injectable drugs for chronic conditions
- Advanced imaging for chronic conditions
- Specialty Referrals for chronic conditions
- Mobility Treatment/Devices
- Hearing Aids
- Sleep Studies
- Cranial Orthoses

To ensure our members are properly cared for, please follow the guidelines below when submitting your request:

- Check benefits and eligibility with the health plan
- Authorization form should be completed in full with all required fields
- All requests require clinical documentation to determine medical necessity
- Do not schedule appointments prior to authorization approval – we do not review for retroactive services

Prior authorization requests are reviewed by clinical and medical staff such as doctors and nurses. To meet state and national standards, the reviewer uses current clinical guidelines to decide if the request is medically necessary. When a prior authorization request is authorized, modified, or denied a copy of the guideline, protocol or other similar criteria, on which the decision was based, can be requested, by calling Santé Community Physicians at (559) 228-2905 or at the following Health Plan's websites:

Medi-Cal
https://files.medi-cal.ca.gov/pubsdoco/manuals_menu.aspx

Anthem Blue Cross Medi-Cal:
https://www.anthem.com/ca/provider/policies/clinical-guidelines/
https://aimspecialtyhealth.com/resources/clinical-guidelines/

Health Net CalViva:
https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/medical_policies.html
https://www.healthnet.com/content/healthnet/en_us/providers/pharmacy/policies.html
https://www.evicore.com/provider/clinical-guidelines

Santé Physicians Utilization Management department utilizes a hierarchy of criteria when making coverage determinations for each line of business. Depending on line of business, the following criteria may be used.

1. Eligibility and benefits (Evidence of Coverage)
2. State-specific and Federal guidelines or mandates
3. Health Plan Guidelines and Benefit Interpretation Policies
4. InterQual, Adult and Pediatric
5. Apollo Managed Care Guidelines
6. AIM Clinical Appropriateness Guidelines
7. National Comprehensive Cancer Network
8. Medical Group/IPA Policy

If your request is approved, you will be notified of the approval via fax. This notice includes the member's information and authorization information such as the authorization number, valid dates, and the services approved. In some instances, you will need to forward this letter to the provider of services when applicable (DME vendor, hospital, specialist, etc.). A letter of approval will also be mailed to the member.

If your request is modified or denied, the provider will receive a copy of the member's notification letter via fax. This notice includes the member's information, authorization information, as well as listing the name and contact information for the practitioner responsible for this decision. The determination letter will be mailed to the member and includes important information such as their appeal rights if they do not agree with our decision.

Clinical Appeals

Members can appeal their authorization denial by submitting an appeal to their health plan. Their appeal rights and instructions including the mailing address and telephone number are included in the member denial letter.

Providers can submit an appeal to the member's health plan on the member's behalf, or call the Santé Chief Medical Officer to request a Peer to Peer at (559) 228-4455.

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

Anthem Blue Cross
Attn: Grievance Coordinator
P.O. Box 60007
Los Angeles, CA 90060-0007
Phone: 1-800-407-4627 or 1-888-757-6034

CalViva Health
Member Appeals and Grievances Department
P.O. Box 10348
Van Nuys, CA 91410-0348
Phone: 1-800-675-6110
Fax: 1-877-713-6189

Common UM Denials

- Cosmetic
- Not a plan benefit
- Inadequate medical justification
- Conservative treatment or required imaging (x-ray) prior to Complex Imaging requests
- Incomplete notes or lack of documentation
- Services can be provided by an in-plan provider
- Failure to see an in plan specialist prior to requesting OON
- Alternate service recommended
- Does not comply with UM guidelines

Referrals

Primary Care Physicians (PCPs) act as care 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 available to be used by PCPs when directing patients to these providers.

This policy will not apply in situations where patients are seen on an emergent basis or when utilizing one of the self-referring options. Referrals written after a service has been performed will not be honored.

Referral Process

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. Referrals can also be sent electronically using EPIC.

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.) Referrals must include dates, diagnoses and diagnosis codes. Fax or mail a copy of the referral form to the Specialist Provider.

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 at non-plan rates, and the referring physician will be monetarily penalized.

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 non-plan rates.
- 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.
- Self-referral options are the only exception.

CARVED OUT SERVICES

Santé Physicians IPA must follow State Department of Health Services (DHCS) Agreement No. 04-36069, Exhibit A, Attachment 11, Utilization Management [CA Health & Safety Code, Sections 123800-123995. Which identifies types of Carved Out Programs and how members and practitioners can obtain access to Carved Out Services

Coordination and collaboration of the member's care is documented between PCP and referred service.

- The medical record must reflect collaboration between the Regional Center/Early Start/Early Intervention program with the PCP (i.e. MD notes [DDS or ES/EI provider], referral from or to the Regional Center and/or Early Start program for ages 0-3)
- The medical record must reflect coordination of specialist services with the Health Plan network.
- The medical record must reflect those members with developmental disabilities, eligible for Home and Community-Based Services (HCBS) Waiver have been referred.
- The medical record must reflect the member has received all medically necessary covered diagnostic, preventive and treatment service through their PCP.

Carved Out Programs include:

- CCS is a state funded program for children up to 21 years, who are residents of California and meet other qualifications, with specific qualifying diseases/health problems. CCS will arrange for health care practitioner treatment for children with special healthcare needs.
- WIC is a federally funded health and nutrition program of the Food and Nutritional Service (providing food checks and nutritional education) for eligible low income pregnant or nursing women, infants and children under 5 years, run by the Department of Public Health.
- EPSDT (Early Periodic Screening Diagnosis and Treatment) is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. Federal law requires that Medicaid cover a very comprehensive set of benefits and services for children, different from adult benefits.
- Blood Lead Level (BLL) screening and reporting as part of EPSDT
- Early Start is a federally required state funded program of the California Department of Developmental Services for families whose infants or toddlers (from birth to 3 years) have a developmental delay or disability or an established risk condition with a high probability of delay. Teams of service coordinators, healthcare practitioners, early intervention specialists, therapists and parent resource specialists evaluate and assess infants and toddlers and provide appropriate early intervention and family support services.
- Regional Centers are a state funded program of the California Department of Developmental Services. California has 21 Regional Centers with more than 40 offices that serve qualifying individuals with developmental disabilities and their families.

Central Valley Regional Center serves the counties of Fresno, Kings, Madera, Mariposa, Merced, and Tulare

Heather Flores, Executive Director
4615 North Marty
Fresno, CA 93722-4186
Telephone: (559) 276-4300
Fax: (559) 276-4360
Website: www.cvrc.org

- Community-Based Adult Services (CBAS) offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.

- AIDS and AIDS related conditions Waiver Program offers services provided include: case management, skilled nursing, attendant care, psychotherapy, home-delivered meals, nutritional counseling, nutritional supplements, medical equipment and supplies, minor physical adaptations to the home, non-emergency medical transportation,

and financial supplements for foster care.

- Dental: Denti-CAL: (800) 322.6384
- Direct Observation Therapy for Treatment of Tuberculosis (DOT)
- Drug and Alcohol Treatment
- Local Education Agency (LEA) Assessment Services

Mental Health:

- Anthem Blue Cross/Wellpoint Behavior Health (888) 831-2246
- Health Net/Managed Health Network (MHN) (888) 426-0030
- Fresno County Department Behavioral Health (559) 600-6899

Enrollees receiving series from the following care out programs may be required to disenroll from the health plan:

- In-Home Medical Care Waiver Program – In-Home Operations (IHO), Home and Community-Based Services (HCBS)
- Long Term Care
- Major Organ Transplants, (For enrollees under 21, refer to CCS)
- Multipurpose Senior Services Waiver Program – Disciplinary Senior Services Program (MMSP)
- Skilled Nursing Facility Waiver Program

Disenrollment process
Referring enrollees will be handled by Customer Service and referred to the Health Plan Medi-CAL Member Service Department to initiate disenrollment for enrollees who must disenroll to be eligible for certain carve out programs and services as listed above.

FAMILY PLANNING SERVICES

Santé Physicians IPA allows members to access any qualified family planning practitioner/provider in-network or out-of-network per State Department of Health Services (DHCS) Agreement No. 04-36069, Exhibit A, Attachment 5, Utilization Management 2, Pre-authorization and Review Procedures

Santé Physicians IPA does not require prior authorizations for the following Family Planning Services:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Limited history and physical exam
- Lab tests if medically indicated as part of decision-making process to choose a contraceptive method
- Follow-up care for complications related to contraceptive methods issued by the family planning practitioner
- Provision of contraceptive pills, devices, and suppliers
- Tubal Ligation
- Vasectomies
- Pregnancy and Counseling

Pursuant to state law, a 12-month supply of FDA-approved, self-administered hormonal contraceptives such as oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed or furnished at one time by a provider or pharmacist including out-of-network providers or at a location licensed or authorized to dispense drugs or supplies is covered.

Santé Physicians IPA must not impose utilization controls limiting the supply of FDA-approved, self-administered hormonal contraceptives dispensed or furnished by a provider, pharmacist, or other

authorized location to an amount that is less than a 12-month supply.

STERILIZATION CONSENT PM330

Prior to performing any sterilization, or any invasive procedures or treatment, Santé Physicians IPA practitioners must complete the PM 330 Consent for Sterilization Form, as required per *[CCR-Title 22, 51305.1-51305.4 42 C.F.R. Sections 50.201-50.210 and Section 1396][DHCS State Contract]*

- Prior to performing any sterilization or any invasive procedures or treatment, Santé Physicians IPA practitioners must complete the PM 330 Consent for Sterilization Form, as required by law.
- Patient to be sterilized must be 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 must be provided if there is evidence that the patient does not understand the language and/or text of the informed consent process
- Physician completes section information as applicable and signed and dated 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 must be 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
- PM 330 form (sterilization consent) is reviewed at the time of claims payment
- Provision of DHCS Booklet on Sterilization is documented in the medical record

Sterilization booklet may be obtained at http://www.dhcs.ca.gov/Pages/PermanentBirthControl.aspx

A Tutorial on Completing the PM330 is available at http://www.familypact.org/Default.aspx?PageID=11657365&A=SearchResult&SearchID=7875672&ObjectID=11657365&ObjectType=1

The PM 330 Consent for Sterilization Form may be obtained at the Family PACT Website www.familypact.org

Behavioral Health

A referral from the Primary Care Physician is not necessary for members to access Behavioral Health Services 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)*

Anthem Blue Cross
Wellpoint Behavioral health 1-888-831-2246

Health Net CalViva
Mental Health Network 1-888- 426-0030

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

Comprehensive Perinatal Services Program (CPSP) is a state funded program run by the California Department of Public Health that provides services to all pregnant women from conception to 60 calendar days postpartum per the State Department of Health Services (DHCS) Agreement 04-36069 Exhibit A, Attachment 10 Pregnant Women [MMCD APL 12-001]

- All Santé Physicians IPA practitioners must offer pregnant women CPSP services and refer high-risk pregnancies to appropriate specialists including Perinatologists and have access to genetic screening with appropriate referrals and coordinate care with CPSP certified providers.
- A description of the services available to enrollees who agree to participate in CPSP including;
  1. initial assessment with evaluation of risk factors
  2. nutritional services
  3. health education
  4. psychosocial services
  5. referrals, as needed
  6. postpartum assessment

- Requires providers to provide services to pregnant enrollees in accordance with the most recent standards of the American College of Obstetrics and Gynecologists at a minimum.
- If pregnant women decline CPSP services, Santé Physicians IPA practitioners have the women sign an Acknowledgement Form stating they were offered services and declined. Participation in CPSP is voluntary.
- Santé Physicians IPA can obtain a copy of this form from the online Provider Operations Manual or the Website
- http://www.cdph.ca.gov/pubsforms/forms/Pages/MaternalandChildHealth.aspx.
- Acknowledgement Form must be retained in the woman's file/chart

All Santé Physicians IPA practitioners (regardless of CPSP certification) must utilize CPSP tools, including a comprehensive risk assessment tool that is comparable to American College of Obstetrics and Gynecologists (ACOG) and CPSP Standards to document Prenatal and Postpartum Care.

CPSP Provider Manual may be obtained from the following Website:
http://www.cdph.ca.gov/programs/CPSP/Pages/default.aspx

CHILD HEALTH and DISABILITY PREVENTION PROGRAM (CHDP)

CHDP is a preventive program that delivers periodic health assessments to low income children and youth in California. CHDP provides care coordination via the PCP 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. Coverage is free to Medi-Cal recipients from 0–20 years of age. If a medical problem is discovered, Medi-Cal will pay for treatment. Members may also qualify for the CHDP program if they have a low-to-moderate income and are 1–18 years of age.

Santé Physicians IPA will follow State Department of Health Services (DHCS) Agreement 04-36069 Exhibit A, Attachment 10 LA Care Contract. Santé Physicians IPA must have a method for identification of eligible contracted CHDP practitioners/providers. (Per the LA Care Health Plan contract, Physicians that see LA Care members under the age of 16 must be CHDP certified)

- Services must be provided in accordance with the most current CHDP standards
- Performance of the CHDP age appropriate assessment must be conducted at the time of the Initial Health Assessment (IHA)
- Refusal of CHDP services are documented in member's medical record.
- The initial assessment must include , or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age, and an age appropriate Individual Health Evaluation Behavioral Assessment (IHEBA)

- Practitioners must follow AAP periodicity tables. This schedule requires more frequent visits than does the periodicity schedule of the CHDP schedule.
- Practitioners must have a Referral process to California Children's Services (CCS), Regional Center, Early Start/Early Intervention/DDS, County Mental Health, and Women, Infants and Children Program (WIC), EPSDT
- Practitioners must for monitor and improve utilization of CHDP services including follow up to ensure services are provided
- Santé Physicians IPA must have a current list of CHDP certified practitioners and providers
- CHDP education must be completed by new hires, providers and staff, inclusive of how to access a CHDP paneled practitioners, CHDP Standards and updates, at least annually

Medi-Cal/CCS Referrals

The Utilization Management Department will, whenever possible, identify all Medi-Cal members and refer any appropriate Medi-Cal members to California Children Services (CCS). This identification process will be done in conjunction with other operational departments of Santé Physicians and information provided by the Health Plans.

- Department staff members identify children with potentially CCS eligible conditions and arrange for their timely referral to the local or dependent CCS office. California Children's Services' (CCS) are carved out services. Referral process includes:
- Santé Physicians IPA follow-up with CCS until a final outcome of the CCS deferral (approval or denial) from CCS is received
- Santé Physicians IPA provision of all medically necessary covered services until CCS eligibility is confirmed
- Santé Physicians IPA immediate referral of all potential or actual CCS cases to local CCS office, not to exceed 24 hours from date of identification with all supporting documentation
- Coordination of care is done by following up on all CCS referrals to facilitate care between the enrollee, the PCP, and CCS.

DENTAL SERVICES – INTRAVENOUS SEDATION AND GENERAL ANESTHESIA COVERAGE

To comply with All Plan Letter (APL) 15-012 and the requirements for MCPs to cover intravenous (IV) sedation and general anesthesia services provided by a physician in conjunction with dental services for managed care beneficiaries in hospitals, ambulatory medical surgical settings, or dental offices. APL 15-012 supersedes Policy Letter (PL) 13-002. This APL identifies information that MCPs must review and consider during the prior authorization process as described and detailed in the IV sedation and general anesthesia for dental procedures.

Medi-Cal beneficiaries enrolled in MCPs are entitled to dental services under IV sedation and general anesthesia when medically necessary in an appropriate setting. Santé Community Physicians must provide prior authorization for IV sedation and general anesthesia for dental services using the guidance in Attachment A

Santé Physicians must assist providers and beneficiaries with the prior authorization process as a form of care coordination to avoid situations where services are unduly delayed.

APL 16-006, End of Life Services

Terminally ill members, age 18 or older with the capacity to make medical decisions are permitted to request and receive prescriptions for aid-in-dying medications if certain conditions are met. Provisions of these services by health care providers is voluntary and refusal to provide these services will not place any physicians at risk for civil, criminal or professional penalties. End of Life Services include consultation and the prescription of an aid-in-dying drug. EOL services

are a “carve out” for Medi-CAL Managed Care Health Plans (MCP’s) 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 the MCP, and must be completed by a Medi-CAL FFS attending physician, or a Medi-CAL FFS consulting physician.

3. Alternatively, if the MCP 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 MCP physician should advise the member that following the initial visit he or she must select a Medi-CAL FFS physician in order for all of the remaining requirements to be satisfied.

APL 18-020 Palliative Care

Palliative care consists of patient-and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the MCP contracts 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. Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.

Santé Physicians provides contracted practitioners with access to the All Plan Letters (APL) and guidelines found on the Santé Medi-CAL website.

Organization informs contracted practitioners about:
i). Palliative Care Program
ii).Referral Process

APL 18-012 HEALTH HOMES

Medicaid health homes 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.

MCP is responsible for providing 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.

Policies and Procedures describe:
Organization informs contracted practitioners about:
i). Health Homes Program
ii). Referral Process

Santé Physicians provides contracted practitioners with access to the All Plan Letters (APL) and guidelines found on the Santé Medi-CAL website.