Utilization Management Timeliness Standards
Centers for Medicare and Medicaid Services (CMS)

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.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
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.	▪ 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, 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	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

Type of Request	Decision	Notification Timeframes
	expedited determination.	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 (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.

[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.

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.

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

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
			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
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.

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.

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.

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.

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
(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 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	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

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 <u>Denial and Modification</u> to Practitioner and Member**
	for service **Additional information <u>incomplete or not received</u>** • 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	<u>Practitioner</u>: Within 24 hours of making the decision <u>Member</u>: None Specified	the receipt of the request for service <u>Practitioner</u>: Within 2 working days of making the decision <u>Member:</u> 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	<u>Practitioner</u>: Within 24 hours of making the decision <u>Member</u>: None specified	<u>Practitioner</u>: Within 2 working days of making the decision <u>Member</u>: 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	**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		

<u>Working day(s):</u> 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**
regain maximum function. • Additional clinical information required	• Note: The time limit may be extended by up to 14 calendar 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	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**
	information reasonably necessary and requested by the plan to make the determination **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 chose 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

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 <u>Denial and Modification</u> to Practitioner and Member**
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 <u>is received</u>, 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	<u>Member & Practitioner</u>: None specified	<u>Member & Practitioner</u>: Within 30 calendar days from receipt of the information necessary to make the determination
	Additional information <u>incomplete or not received</u> • 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 information	<u>Member & Practitioner</u>: None Required	<u>Member & Practitioner</u>: Within 30 calendar days from receipt of the information necessary to make the determination
Hospice - Inpatient Care	Within 24 hours of receipt of request	<u>Practitioner</u>: Within 24 hours of making the decision <u>Member</u>: None Specified	<u>Practitioner</u>: Within 2 working days of making the decision <u>Member</u>: Within 2 working days of making the decision

<u>Working day(s):</u> mean State calendar (State Appointment Calendar, Standard 101) working day(s).

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Policy: 1.01
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose and Scope

The Utilization Management (UM) Program is designed to monitor, evaluate, and manage the cost and quality of healthcare services delivered to all members of the HMO Health Plans contracted with Santé Physicians IPA. This program will ensure that:

1. Services are medically necessary and are delivered at appropriate levels of care. When making a determination based on medical necessity, only information reasonably necessary to make a decision is requested. [CA Health & Safety Code § 1367.01(g)]

2. Authorized care matches the benefits defined in the member's health plan.

3. Services will be provided by Santé Physicians contracted providers or health plan (e.g. hospital network) contracted providers unless authorized by the Utilization Management Committee or the Medical Director. Services provided by non-Plan providers will not be authorized unless they are emergent in nature, the services cannot be rendered by a contracted provider, they meet Continuity of Care guidelines and they are medically necessary. The health plan staff will be notified immediately to discuss the use of a non-contracted (non-credentialed) provider based on the health plan contract.

4. Decisions about the following require medical necessity review:
   • Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits.
   • Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.
   • Care or services whose coverage depends on specific circumstances.
   • Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
   • Out-of-network services that are only covered in clinically appropriate situations.
   • Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
   • "Experimental" or "investigational" requests covered by the organization.

Decisions about the following do not require medical necessity review:
• Services in the member's benefits plan that are limited by number, duration or frequency.
• Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
• Care or services whose coverage does not depend on any circumstances.
• Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living.
• "Experimental" or "investigational" requests that are always excluded and never deemed medically necessary under any circumstance. In these instances, the organization either:
  – Identifies the specific service or procedure excluded from the benefits plan,
  Or
  – If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, the materials state that members have the opportunity to request information on excluded services or procedures and that the organization maintains internal policies or criteria for these services or procedures.

5. Hospital admissions and length of stay are justified.

6. Services are not over utilized or under utilized.

7. Appropriate care is offered in a timely manner and is quality-oriented.

8. Reconstructive surgery will be authorized to correct or repair abnormal structures of the body caused by:·Congenital defects,·Developmental abnormalities,·Trauma, Infection·Tumors, or·Disease in order to either improve function or create a normal appearance (to the extent possible).

9. Scheduling is efficient for services and resources.

10. Costs of services are monitored, evaluated, and determined to be appropriate.

11. Santé Physicians complies with national coverage decisions, general Medicare coverage guidelines, written coverage decisions of local Medicare contractors, guidelines, standards, and criteria set by governmental and other regulatory agencies.

12. The Santé Physicians IPA will maintain compliance with the regulations set for the specific contracted member populations (e.g. Commercial, Medicare, MediCal).

13. The Santé Physicians IPA utilizes standard criteria and informational resources to determine the appropriateness of healthcare services to be delivered. This

criterion also is to include behavioral health, and Outpatient and Inpatient. The criteria will be reviewed and updated at least annually and more frequently if required. Criteria and any changes made will be presented to the UMC for review and approval in conjunction with annual UM program. The UMC minutes will reflect the committee's approval or recommendations.

The criteria are, but are not limited to:

Commercial HMO Members
Santé Physicians uses the following hierarchy when making Commercial HMO coverage determinations:

1. Eligibility and benefits (Evidence of Coverage)
2. State-specific and Federal guidelines or mandates
3. Health Plan Guidelines and Benefit Interpretation Policies
4. WPATH Standards of Care for the Health of Transgender and Gender Diverse People
5. InterQual, Adult and Pediatric
6. Apollo Managed Care Guidelines
7. Carelon Clinical Appropriateness Guidelines for Diagnostic imaging and Sleep Disorders
8. National Comprehensive Cancer Network
9. Medical Group/IPA Policy

Medicare HMO Members
Santé Physicians uses the following hierarchy when making Medicare HMO coverage determinations:

1. Plan Eligibility and Coverage (benefit plan package or EOC)
2. CMS Criteria
    a. National Coverage Determination (NCD)
    b. Local Coverage Determination (LCD)
    c. Local Coverage Medical Policy Article (LCA)
    d. Medicare Benefit Policy Manual (MBPM)
3. Health Plan Criteria
4. InterQual, Adult and Pediatric
5. Carelon Clinical Appropriateness Guidelines for Diagnostic imaging and Sleep Disorders
6. National Comprehensive Cancer Network
7. Medical Group/IPA Policy

Medi-CAL Members
Santé Physicians uses the following hierarchy when making Medi-CAL coverage determinations:

1. Plan Eligibility and Coverage (benefit plan package or EOC)
2. Medi-CAL Criteria

3. Health Plan Criteria
4. InterQual, Adult and Pediatric
5. Carelon Clinical Appropriateness Guidelines for Diagnostic imaging and Sleep Disorders
6. National Comprehensive Cancer Network
7. Medical Group/IPA Policy

14. The Utilization Management Program's plan, policies and procedures will be reviewed, and revised on at least an annual basis by the Utilization Management Committee. The Utilization Management Program is updated more frequently if there is an organizational or structural change or if new legislation is enacted that impacts the UM process.

15. The utilization management team of physicians, licensed staff, and unlicensed staff carry out the responsibilities designated for their level of expertise. A behavioral health practitioner is actively involved in implementing the behavioral health aspects of the UM Program.

16. The Utilization Management Program will be integrated with the Quality Management Program to ensure continuous quality improvement

17. A written Utilization Management Plan will be submitted annually to the contracted health plans.

18. The Utilization Management Program will be approved annually by Santé Physicians' Board of Directors.

Goals and Objectives:

The Utilization Management Program goals and objectives are to:

1. Provide access to the most appropriate and cost efficient healthcare services.

2. Ensure that authorized services are covered under the member's health plan benefits.

3. Develop systems to evaluate and determine which services are consistent with accepted standards of medical and behavioral health practice.

4. Perform peer review in conjunction with the Quality Improvement Program when it is necessary.

5. Coordinate thorough and timely investigations and responses to member and provider grievances that are associated with utilization issues.

6. Initiate necessary procedural revisions to prevent problematic utilization issues from reoccurring.

7. Ensure that services that are delivered are medically necessary and are consistent with the patient's diagnosis and level of care required.

8. Ensure Santé Physicians IPA does not compensate practitioners or individuals for denial decisions, nor offer incentives to encourage denial decisions. (refer to UM Affirmative Statement)

9. Santé Physicians IPA avoids a conflict by completing the Annual Affirmative Statement by all UM staff, to include non-clinical, clinical, physician and UM Committee members. UM decision-making is based on appropriateness of care and service and existence of coverage. Santé Physicians does not compensate practitioners or individuals for denials, does not offer incentives to encourage denials, and does not encourage decisions that result in underutilization. Santé Physicians ensures independence and impartiality in making referral decisions that will not influence hiring, compensation, termination, promotion and any other similar matters.

10. Santé Physicians IPA does not conduct Economic Profiling in any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

11. Facilitate communication and develop positive relationships between members, physicians, and health plans by providing education related to appropriate utilization.

12. Evaluate and monitor healthcare services provided by Santé Physicians IPA contracted providers by tracking and trending data.

13. Monitor continuity and coordination of care.

14. Identify over utilization and under utilization of services.

15. Enhance the delivery of care by rewarding physicians and providers for sound utilization practices and exceptional quality of service.

16. Identify "high risk" members and ensure that appropriate care is delivered by accessing the most efficient resources.

17. Reduce overall healthcare expenditures by developing and implementing effective health promotion programs.

18. Utilization Management data will be used in the process of re-credentialing providers.

19. Annually, behavioral health data is monitored for performance of data types against established thresholds for each product line to detect under- and over-utilization.

Policy:

Utilization review criteria based on reasonable medical evidence will be used to make decision pertaining to the utilization of services. Santé Physicians will have appropriate actively practicing health care practitioners involved in the development and/or adoption and application of standardized criteria. This includes behavioral health as well.

All services authorized by the Utilization Management (UM) and Behavioral Health Staff will be evaluated to determine medical necessity based on criteria listed under Procedure and Scope, item 3. The criteria are reviewed, revised (as appropriate) and approved on at least an annual basis by the Utilization Management Committee. A designated senior physician has substantial involvement in the implementation of the UM Program. The designated senior physician shall hold an unrestricted license to practice in the state of California. Santé Physicians participating providers outside of the Utilization Management Committee assist in the review and revision or acceptance of the criteria. The criteria are available upon request to all Santé Physicians participating providers, our members, and to the public. Criteria will be provided in printed form and mailed, faxed or emailed to the requestor. The following notice accompanies disclosure of criteria:

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

1. A mechanism for checking the accuracy and consistency of application of the criteria across the reviewers is present.

2. Application of the criteria which justifies appropriateness of services will be clearly documented and available, upon request, to participating physicians.

3. Documentation for case review and authorization/denial/modified of services shows that efforts are made to obtain all necessary information, including pertinent clinical information, and consultation with the treating physician, as appropriate. This is to include behavioral health, as well.

4. Santé Physicians IPA providers are not restricted in advocating on behalf of a member or advising a member on medical care. This advocacy may include, but not be limited to, treatment options (without regard to plan coverage), risks, benefits and consequences of treatment or non-treatment, or a member's right to refuse medical treatment and to self-determination in treatment plans.

5. Santé Physicians IPA approved policies and procedures for the referral/authorization process and associated time frames will be implemented and monitored.

6. Pre-authorization, concurrent review and case management decisions and processes are supervised by qualified licensed medical professionals / Behavioral Healthcare practitioners. Physician consultants are utilized to review cases from the appropriate specialty areas of medicine, surgery and behavioral health (and are certified by one of the American Boards of Medical Specialties).

7. Only a physician can make the decision to deny or modify service after conducting a review for medical appropriateness. Reasons for denial or modification are clearly documented and available to the member. Notification to the member and provider of a denial/modification includes appeal process information. The Vice President for Medical Affairs and Education reviews all denials and modifications.

8. UM Decisions making is based only on appropriateness of care and service. Santé Physicians IPA does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision-makers do not encourage decisions that result in under utilization.

SEE ATTACHMENT: Affirmative Statement Regarding Incentives

9. Statements affirming the above are distributed to and signed by all UM staff and decision making practitioners annually. Staff and practitioners may include Medical Director, UM director/ Manager, UM staff, any management of staff or staff who make UM decisions on behalf of the PMG.

10. Determinations are made in a timely manner, and the urgency of the situation always is taken into consideration.

SEE ATTACHMENT: ICE Time Standards For Decision Making & Notification and Behavioral Health Standards For Decision Making & Notification.

11. Member and provider grievances will be investigated promptly, and a written response will be submitted to the concerned party within a designated time frame e.g. 48 hours or two business days. (Q.I.)

12. There are documented mechanisms to evaluate the effects of the program using member and provider satisfaction data, staff interviews, and/or other appropriate methods.
    - Santé Physicians gathers information annually from members and providers regarding their satisfaction with the UM process.

- Identified sources of dissatisfaction are addressed.
- Benchmark of 96% for member and provider surveys.

13. Utilization tracking and trending data will be submitted on a regular basis to the Utilization Management Committee and the Santé Physicians contracted health plans. The data will be analyzed by the Utilization Management Committee to determine outcomes related to over utilization or under utilization of services. The Committee will make recommendations for necessary corrective action based on the findings. After corrective action has been implemented, a re-evaluation will be done, and the Committee will review the results.
    (Refer to UM Policy Utilization Data/Reporting 3.05 Over & Under Utilization)

14. Quality-related issues will be referred to the Quality Improvement Committee. The UM and QI Committees will work together to resolve any cross-related issues or problems.

15. Focus studies will be conducted to assess the appropriate use of new or existing medical technologies. The focus studies will include criteria that are established by qualified professionals.

16. The Utilization Management Program plan will include the effective processing of prospective, concurrent and retrospective review determinations by qualified personnel. The areas of review will include:

    Emergency Department authorizations
    Inpatient hospitalizations
    Outpatient surgeries
    Behavioral Health
    Selected outpatient services
    Rehabilitative services
    Selected ancillary services
    Home healthcare services
    Selected pharmaceutical services
    Selected physician office services
    Out-of-network services

17. Provider and member appeals will be handled efficiently according to Santé Physicians policy and procedure (which includes compliance with regulatory time frames).

18. A viable case management program will exist which clinically and administratively identifies, coordinates, and evaluates the services delivered to those members which require close management of their care.

19. The Utilization Management Committee will meet on a regularly scheduled basis, at least quarterly, with additional meetings as necessary.

20. The UM Committee will report to the Santé Physicians IPA/Board of Directors at least on a quarterly basis.

21. The Utilization Management Program's plan policies and procedures will be reviewed, revised and approved on at least an annual basis by the Utilization Management Committee.

22. The approved annual Utilization Management Plan will be submitted to the contracted health plans. Other Utilization Management reports will be submitted to the health plans according to contractual agreements.

23. Provider and member education will be offered, evaluated, and improved on a continual basis. Health education programs that are in compliance with all applicable regulations will be available to the members. Appropriate data will be reported to the encounter system. Contracted health plans will receive health plan-specific reports on the encounter data. The data should be submitted in an accurate and timely manner.

24. Contracted health plan surveys that are conducted annually will involve the cooperation of the Santé Physicians staff.

Organizational Structure and Responsibility:

The Santé Physicians IPA organizational chart accurately reflects the utilization management staff and committee reporting structures. Staff positions and committee descriptions explain all associated responsibilities and duties. The staff ratios are equivalent to the organization's needs and are accommodated by the utilization management program's budget. Reporting relationships are clearly defined. Performance objectives are included in the staff evaluations. Interdepartmental coordination of managed care utilization of services is clearly delineated in the description of each department.

1. Santé Physicians IPA Board of Directors.
   a. Responsibilities include the development and maintenance of the Utilization Management Program. The responsibility for creating and implementing the UM program's infrastructure is delegated to the Utilization Management Committee.
   b. The Santé Physicians IPA Board of Directors oversees all Utilization Management Program activities, therefore, the UM Committee reports to the Santé Physicians IPA on at least a quarterly basis. Documented summaries of utilization statistics and focus study reports are presented.
   c. All policy, procedure, and program changes require the Santé Physicians IPA Board of Directors' approval.

d. The Santé Physicians IPA Board of Directors may delegate additional responsibilities to the Utilization Management Committee, as it is necessary.

2. Santé Health System Service Integrator
   a. Responsibilities include overseeing the organization and management of the Utilization Management Program with a focus on the program's financial availability, the allocation of resources and staffing, and the interdepartmental effectiveness of the program.

3. Utilization Management Committee Chairperson
   a. Responsibilities include communication with UMC members, facilitator for UMC meetings and review and approval of proposed agendas and UMC minutes. Promotes cooperation and collaboration of PMG providers.
   b. Works with the VP Medical Affairs and UMC members in analyzing utilization trends and patterns. Represents the PMG/IPA in communicating findings and recommended interventions to IPA membership.
   c. The chairperson of the UMC is responsible for ensuring that the staff and providers carry out the recommendations of the committee involved in the utilization management process.
   d. The chairperson of the UMC is responsible for oversight of UMC development, implementation and evaluation of processes that allow for Quality, cost effective services.

4. Vice President for Medical Affairs and Education
   a. Responsibilities include the development and implementation and ongoing review of the Utilization Management Program, the Quality Management program, the Education program, the Credentialing process, and the Wellness program. The VP coordinates the work of Santé Health System and Community Health System and promotes cooperation and collaboration of PMG providers. The VP represents the PMG/IPA at meetings and functions.
   b. Works with the CEO and President of Santé Health Systems in determining the needs of the PMG/IPA. The program's effectiveness is enhanced under the governance of the Vice-President for Medical Affairs and Education who functions in a full time capacity.

5. Case Management/Utilization Management Service Coordinator.
   a. Responsibilities include the operational execution of the Utilization Management Program under the direction of the Santé Health System Service Integrator and the Vice President for Medical Affairs and Education. Case Management/UM service coordinator is responsible for managing the UM staff which may include the following positions:

- Utilization Review Coordinator/ Utilization Management Clinical Partner
- Nurse Practitioner/Physician Assistant Clinical Partner
- Case Management Coordinator/ Case Manager Clinical Partner
- HMO Coordinator Administrative Partner
- Catastrophic Case Manager Clinical Partner
- UM Administrative Partner

6. UM Supervisors
    a. Provide day-to-day supervision of assigned UM staff
    b. Participate in staff training
    c. Monitor for consistent application of UM criteria by UM staff for each level and type of UM decision
    d. Monitor documentation for adequacy
    e. Available to UM staff on site or by telephone

Utilization Management Committee:

The Utilization Management Committee oversees the implementation of comprehensive, systematic, continuous processes that make the Utilization Management Program effective. The UM Committee meets its program objectives in part by conducting prospective, concurrent, and retrospective review of services for inpatient hospitalizations, emergency care, outpatient surgery, rehabilitation, home health and hospice care. Selected services from outpatient, ancillary, and physician offices also are reviewed. The UM Committee monitors quality, continuity, and coordination of care as well as over utilization and under utilization of services. Any perceived or actual utilization management problems are addressed by the UM Committee. The Quality Improvement and Utilization Management Committees work together on overlapping issues.

The UM Committee actively manages utilization of services by making the most appropriate use of available healthcare resources. Sound utilization plans are defined, developed and executed by the Utilization Management Committee. The utilization plans meet budget constraints and reflect support and consistency involved with aggregate services. The UM Committee oversees and monitors all delegated utilization management activities.

The entire period of care from the first treatment encounter to the member's return to a healthy state is effectively managed by the Santé Physicians IPA providers, staff, and ultimately the UM Committee. The UM Committee recognizes and applies appropriate medical benefits to the management of cases. Treatment guidelines which lead to the best health status outcomes are reviewed, revised, approved, and utilized by the UM Committee. The UM Committee actively develops, implements, and evaluates the most effective and efficient treatment pathways which return members to optimal states of health.

Complicated and costly cases are managed closely by the UM Committee to ensure that the most cost-effective services are identified, coordinated, implemented, and evaluated on a continual basis. This long-term process involves the UM Committees use of appropriate clinical, individual, and environmental resources.

The UM Committee establishes and maintains solid avenues of communication and networking between providers, staff, facility and health plan staff, and members.

New and existing technology will be evaluated by the UM Committee, when applicable.

Additionally, the UM Committee may review pharmaceutical services statistics which are illustrated in cost and utilization analysis reports.

Note: Santé Physicians IPA subdelegates only Behavioral Health UM Activities to contractors. Santé Physicians IPA has a documented evaluation of these activities. A description of the delegated contractor's UM program includes:

1. The UM activities which are delegated and for which the contractor is responsible.

2. The reporting requirements of the contractor to the Santé Physicians IPA.

3. The Santé Physicians IPA's evaluation process of the contractor's responsibilities.

4. The Santé Physicians IPA's approval of the delegated contractor's UM program.

5. The Santé Physicians IPA's mechanism for evaluating the contractor's program reports

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT COMMITTEE

Policy: 1.02
Origination Date: 07/1995
Last Review Date: 01/2024

The Utilization Management (UM) Committee will be established as a standing committee of the Santé Physicians IPA which reports to the Santé Physicians IPA Board of Directors.

Structure/Membership:

Physician Members of the UM Committee will be appointed by the Vice President for Medical Affairs and Education in consultation with the UM Committee Chairman, and with the approval of the Santé Physicians IPA Board of Directors. The UM Committee physician membership includes the Vice President for Medical Affairs and Education, the UM Committee Chairman and appointed physicians from the following specialties:

1. Family Practice
2. Pediatrics
3. OB/GYN
4. Surgery
5. Internal Medicine
6. Emergency Medicine - if appropriate
7. Neurology, Gastroenterology or other specialties
8. Behavioral Health

Non-physician UM Committee members will be appointed by the Vice President for Medical Affairs and Education with the approval of the Santé Health System Service Integrator of the Santé Physicians IPA. These members may include:

1. Case Management and Utilization Management Service Coordinator
2. Quality Improvement Coordinator
3. Case Manager
4. Physician Services Coordinator
5. Clerical Support Staff
6. Executive Staff member (e.g., CEO, Administrator)

Representatives from the Claims/Operations, Provider Relations, and Contracting Departments may be asked to attend the meetings. Contracted Health Plans may send staff to attend meetings on a pre-approved basis. The Health Plan staff may attend the part of the meeting that covers members assigned to their plan. The staff must sign a confidentiality statement prior to attending the meeting.

A quorum of at least 3 licensed physician committee members must be present at each meeting. The UM Committee will be composed of a cross-section of primary care and specialist providers, and will meet, at least quarterly. Additional Committee meetings or subcommittee meetings may be scheduled at the discretion of the UM Committee Chairman. The UM Committee members will serve a one year term with the possibility of reappointment for two additional terms. Only physician members of the UM Committee have voting rights.

During the period of time between UM Committee meetings, the Vice President for Medical Affairs and Education or designee may function as an interim committee meeting decision-maker to expedite the referral/authorization process.

Functions:

The UM Committee oversees the timely development and implementation of an effective utilization management program which includes the following:

1. Development of a program that oversees the delivery of high quality care to members in the most cost-effective manner.

2. Determination of authorization for services that reflect effective and efficient utilization practices.

3. Annual review and revision (as appropriate) of all aspects of the Utilization Management Program including the utilization management plan, policies and procedures, annual report summary, and utilization guidelines.

    a. Development and implementation of utilization management policies and procedures.
    b. Development and implementation of an annual utilization management plan.
    c. Review and revision of Santé Physicians IPA approved prospective, concurrent and retrospective review protocols and guidelines to ensure their consistency with standard medical practices. Application of the Santé Physicians IPA approved protocols and guidelines for authorization determination while acknowledging differences for each case and contracted provider feedback regarding the effectiveness of the UM Program.
    d. Evaluation of measurement tools that ensure that protocols and guidelines are interpreted similarly among the reviewers.

4. Oversight of utilization management standard compliance, problem cases, and compliance of providers with Santé Physicians IPA standards and procedures.

5. Identification and investigation of specific and general utilization management problems especially in relation to trending patterns by providers, over utilization and under utilization, resource use, access, and performance.

6. Monitoring of the resolution of utilization problems and overseeing the process of assessment, conclusions, recommendations, actions and follow-up evaluation.

7. Referral of quality problems to the Quality Improvement Committee for review and follow-up.

8. Involvement in peer review activities in conjunction with Quality Improvement.

9. Facilitation of effective utilization management networking between the Santé Physicians IPA and the contracted hospitals and health plans.

10. Conduction of retrospective review and payment determination of claims which have not been adjudicated.

11. Serve as a review group to assist in the interpretation of medical benefit coverage associated with the delivery of necessary and appropriate services.

12. Contribute to comprehensive education programs for the Santé Physicians, IPA providers, staff, and members.

13. Approval of documentation in the minutes of any actions or decisions made by the UM Committee.
    a. Assurance that minutes accurately reflect the activities of the UM Committee meetings.

14. Development of subcommittees and specialty task forces to assist the UM Committee by:
    a. Contributing to the development of primary care physician education sessions regarding specialty care.
    b. Assist in obtaining provider feedback regarding the UM program and utilization management issues.
    c. Analyzing provider utilization, developing or revising utilization guidelines, and delineating the various provider roles.
    d. Monitoring of referrals to non-contracted providers and facilities.
    e. Recommending new specialists to the Membership/Credentialing Committee.
    f. Development of criteria for outcome and focus studies.
    g. Development of clinical pathways to be used as a reference tool by the Santé Physicians IPA providers.

h. Assist in the process for evaluating new and existing technologies.

15. If the Santé Physicians IPA has decided to include a Medical Policy Subcommittee in its structure, communication of any actions or decisions affecting the processes of setting medical policy to the Medical Policy subcommittee who will assist in the determination of the need for policy change. The approved change will be passed on to Santé Physicians IPA staff, contracted providers and health plan staff.

16. The content of the UM Committee meetings will be kept confidential and all members will sign a confidentiality statement that will be kept on file.

17. The UM Committee will report to the Santé Physicians IPA at least on a quarterly basis. Monthly reports to the Santé Physicians IPA are preferable.

18. When necessary, the Utilization Management Committee will serve as a review panel for all member or provider grievances and appeals.

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT COMMITTEE
MEETING MINUTES

Policy: 1.03
Origination Date: 07/1995
Last Review Date: 01/2024

Minutes:

A consistent format will be utilized for the minutes taken at each of the Utilization Management Committee meetings. The minutes will include a list of the members present, those absent, and the names of guests present at the meeting. The minutes sequentially will follow the agenda item topics, and the summary will include the key points discussed for each item. The discussion highlights and summary also will include the Committee's recommendations, actions taken, and the schedule of follow-up activities. Documents or handouts presented at the meetings will be labeled and included as attachments to the minutes. The phrase, "Prepared for the Utilization Management Committee" should be written on all reports, documents, minutes and agendas which are presented to the UM Committee. Committee Minutes will be contemporaneous. All minutes are reviewed, revised and approved by the UM Committee.

In order to maintain confidentiality, all member names will be recorded in codes in the minutes. Confidentiality of the contents and documents of the meetings will be maintained according to California Evidence Code Section 1157.

UM Committee Minutes will be filed separately from other Santé Physicians IPA committee or organizational documents.

Contracted health plan staff may be permitted to review the minutes in the Santé Physicians IPA administrative office. The documents may not be removed from the Santé Physicians IPA office and the content of the documents may not be reproduced in any manner.

See Attachment A: *Utilization Management Committee Attendance Record*
Utilization Management Committee Confidentiality Statement
Case Management Notification Form

SANTÉ PHYSICIANS IPA

Policy/Procedure

PRACTICE GUIDELINES

Policy: 1.04
Origination Date: 07/1995
Revision Date: 01/2024

Purpose:

The Santé Physicians IPA will provide a method of systematically developing statements to assist providers and members to make decisions about appropriate healthcare for specific clinical circumstances and to assess the appropriateness of specific healthcare decisions, services and outcomes. They will provide methods or instruments to monitor and evaluate the extent to which the actions of a provider conform to practice guidelines, medical review criteria and/or standards of quality to provide optimum clinical outcomes.

Scope:

Selection of topics for guideline development will consider high volume, high risk services and procedures and those with the potential for reducing clinically significant and unexplained variations in services and procedures used in the prevention, diagnosis, treatment, management, or outcomes related to the clinical condition and the cost of the condition to all payers, including members.

The following is the Practice Guidelines Policy:

Policy:

1. The Utilization Management Committee is responsible for arranging for the development, periodic review, and updating of clinical practice guidelines that may be used by providers to determine how specific conditions can most effectively and appropriately be prevented, diagnosed, treated and managed.

2. Based on the guidelines produced, the Utilization Management Committee develops medical criteria and performance measures for the monitoring and evaluation of care provided to members.

3. The Utilization Management Committee may appoint multi-disciplinary sub-committees to develop guidelines and criteria. These sub-committees should have representation consistent with services provided and provider panel membership.

4. Guidelines are based upon established national guidelines, where available, scientific literature and prudent practice. Guidelines are peer reviewed and developed by consensus.

5. Guidelines are reviewed at least annually and revised if necessary to ensure that they are consistent with current literature and national guidelines as well as the outcomes and experience of the IPA.

6. Guidelines are provided to providers as they are developed and/or revised through educational sessions, mailings, newsletters and updates to provider manuals.

7. The Utilization Management Committee monitors and evaluates the consistency with which providers follow the guidelines, through defined studies, risk and utilization management reports, member and provider reports, and applicable utilization management information.

Guideline Development:

Guideline development includes the following basic steps:

1. Clearly define the major questions regarding the clinical condition to be addressed including the desired outcomes as well as potential variation in outcomes.

2. Review and analyze the available scientific data for each question.

3. Assess clinical benefits and harms of each intervention.

4. Review estimates of important member outcomes for each intervention being considered.

5. Review current and potential healthcare costs associated with the guideline. Where cost information is available and reliable, provide costs of alternative strategies for the prevention, diagnosis, treatment, and management of the condition.

6. Invite information and comments on guidelines from providers and members.

7. Prepare guideline draft based on the available experience evidence and on professional judgement where experience evidence is insufficient.

8. Submit draft guideline to peer review and other experts.

9. Revise draft guideline based on analysis of comments and information received.

10. Obtain Governing Body approval.

11. Prepare the guideline in a format appropriate for use by providers and members.

12. Distribute guideline to providers per policy.

13. Monitor and evaluate the appropriateness and outcome of guideline used and revise as indicated.

SANTÉ PHYSICIANS IPA

Policy/Procedure

STAFF TRAINING AND EDUCATION

Policy: 1.05
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The Utilization Management Committee will oversee the coordination of training and education programs that will provide the Santé Physicians IPA utilization management staff with the required knowledge and skills to effectively manage utilization-related issues.

Scope:

The ongoing training and education sessions will address issues that influence the effective implementation of the Santé Physicians IPA's approved Utilization Management Program. Staff suggestions for certain topics or programs are encouraged. The educational programs should include but are not limited to the following subjects:

1. Clear documentation of the application of the criteria that justifies appropriateness of services.

2. The accuracy and consistency of the application of guideline criteria.

3. Documentation for case review and authorization/denial of services will include all necessary information.

4. Qualified licensed medical professionals conduct the supervision of pre-authorization, concurrent review and case management decisions and processes.
    a. Licensed medical professionals supervise non-clinical staff.

5. The Medical Director will be involved in the review of complicated cases.

6. Decisions for the denial of service authorizations are made only by the Medical Director.

7. The utilization management staff complete the denial process according to Santé Physicians IPA policy and procedure.

8. Compliance with mandated time frames for completing the utilization review/authorization process.

9. Prompt handling (according to procedure) of member and provider grievances.

10. All staff will conduct program evaluations that include suggestions for improvement.

11. Quality-related issues that affect the utilization management process will be worked on by the quality management staff and the results will be shared with the utilization management staff to improve the UM process.

12. The Utilization Management Program includes the effective processing of prospective, concurrent and retrospective review determinations by the appropriately qualified personnel. The process, problems, and changes in the various areas of review will be continually addressed in staff training. These review areas include but not limited to:
    a. Colonoscopies
    b. Inpatient hospitalizations
    c. Sleep Studies
    d. Selected outpatient services
    e. Rehabilitative services
    f. Selected ancillary services
    g. Home healthcare services
    h. PT/OT/ST
    I. Self -Injectables
    j. Non-plan physician.
    k. Non-plan facility.

13. The case management program will be comprehensively addressed and revisited in follow-up training sessions.

Policy:

1. Administrative staff will provide education sessions for the Santé Physicians IPA staff in order to promote continual professional and personal growth concerned with the management of the utilization of healthcare services.
2. The staff will be involved in both the internal and outside training and education programs. The courses will include internal training sessions, cross training, and seminars put on by organizations outside of the Santé Physicians IPA.

SANTÉ PHYSICIANS IPA

Policy/Procedure

NEW TECHNOLOGY AND PROCEDURES

Policy: 2.01
Origination Date: 07/1995
Last Review Date: 01/2024

Policy:

The individual HMO Corporate Medical Department provides information related to the review of new technologies and procedures to Santé Physicians IPA.

This information is available to the Medical Director/Physician Advisors when a request is received for authorization of any new, non-traditional therapies or procedures.

Standard requests for services classified as Experimental/Investigational will be referred to the Health Plan for medical review and determination within 24 hours of initial receipt of request. Expedited requests must be completed and faxed on the same day of member or physician request. If the request is related to transplants, the information must be sent directly to the Health Plan Case Management Transplant Department. No denial of services considered experimental or investigational will be issued by Santé Physicians IPA. Informational letter to member and practitioner should be issued immediately when sending the experimental/investigational referral to the Health Plan.

Santé Physicians IPA denial notifications will adhere to established timeframes for urgent (2 days), concurrent (1 day) and retrospective (5 days). Denial letters will include instructions for referral to Health Plan for medical review and determination. Decision-making and member notification is done by the Health Plan.

Members receiving denials of experimental/investigational treatment when terminally ill (defined as death before 24 months) or with a life threatening condition (defined as diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or disease or conditions potentially fatal outcomes where the end point of clinical intervention is survival) or seriously debilitating condition (defined as diseases or conditions that cause major irreversible morbidity) may be entitled to an external review/appeal process.
Independent external review organizations may be contracted by the health plan for the review/appeal process.

Additionally, terminally ill members may request a conference (telephonic or in person) when experimental/investigational treatment services have been denied. The member must first have participated in the standard appeal process until resolution or 30 days

have passed (3 days for expedited appeals). Santé Physicians IPA will participate in the conference as requested by the Health Plan and in accordance with AB 55 guidelines.

United Healthcare Policy & Process Flow
When UHC responsible for clinical trial or Carve Out request, Santé UM staff will warm transfer caller to UHC and will remain on the line to explain the request.

- o Transfer members to UHC customer service number on back of the member ID card.
- o Transfer providers to UHC provider line 877-842-3210.

UM staff will be responsible to warm transfer either member or provider with clear understanding of referral request prior to connecting to Health Plan.

Documentation of both member and provider communication will be noted in the referral comments.

Commercial and Medicare members will not receive a Carve Out letter but will receive a telephonic notification.

Santé UM will not approve or deny any experimental or clinical trials.

SANTÉ PHYSICIANS IPA

Policy/Procedure

CHECKING MEMBER ELIGIBILITY AND BENEFITS

Policy: 2.02
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The Utilization Management staff assists in the identification of covered benefits for services that can be delivered to eligible Santé Physicians IPA members.

Policy:

Utilization Management staff will provide members and providers with accurate benefit and eligibility information when authorizing or denying services.

Procedure:

The staff will utilize the appropriate resources to identify member eligibility and benefits related to the requested authorization for service. The resources include the following:

1. Eligibility verification
   a. Computer files
   b. Health Plan monthly eligibility list
   c. Direct contact with the Health Plan

2. Benefits verification
   a. Computer files
   b. Health Plan schedule of benefits
   c. Direct contact with the Health Plan

3. Information is received by the Utilization Management staff via telephone call or fax.

4. The Utilization Management staff verifies eligibility of member.

5. If the member cannot be located in the computer database, member demographics are sent to customer service for verification/input.

6. In cases where a member's benefits are exhausted but the member still needs care, Santé assists the member, if necessary, in obtaining other care. This may include:
    a) Referring the member to Case Management to assist transition to new provider
    b) Obtaining continued care through other sources, e.g. community resources

SANTÉ PHYSICIANS IPA

Policy/Procedure

Benefit Coverage/Legislation

Policy: 2.03
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:
To provide appropriate benefit coverage for medical services as outlined by legislation.

Policy:
Utilization Management staff will approve appropriate coverage for services. Benefit determinations involving professional judgement will be reviewed by a clinical peer (appropriately licensed practitioner). Clinical decisions as well as policies and procedures of the UM Program will comply with applicable federal, state and local legislation and codes.

Procedure:

PKU testing and treatment / SB148

The new law requires coverage be provided for the testing and treatment of phenylketonuria (PKU). Coverage for the treatment of PKU must include those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health professional in consultation with a physician who specializes in the treatment of metabolic decease.

Mastectomy: Reconstructive surgery

Coverage is required for medical services necessary in achieving breast symmetry post mastectomy. Must allow the length of a hospital stay associated to be determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. The delegate may not require a treating physician and surgeon to receive prior approval in determining the length of hospital stay following those procedures. Coverage must include all complications from a mastectomy, including lymphedema. Mastectomy is defined as: "the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes but is not limited to lumpectomy.

Mammogram

Must provide coverage for mammograms upon the referral of 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.

Diabetic Supplies / SB64 / Health and Safety Code 1367.51

Coverage will be provided for any medically necessary education, treatment, equipment and supplies necessary to manage and treat diabetes. Coverage will be provided for the following services/equipment/supplies for the management and treatment of Type I, Type II and gestational diabetes, even if available without a prescription. Services will be provided by appropriately licensed or registered health care professionals upon referral or prescription by a participating physician.

- Out-patient self-management training, education and medical nutrition therapy
- Blood glucose monitors and test strips
- Monitors to assist the visually impaired
- Insulin pumps and related supplies
- Ketone urine test strips
- Lancets /lancet devices
- Pen delivery system
- Podiatric devices to prevent or treat diabetes related complications
- Insulin Syringes
- Visual aids, excluding eyewear, to assist the visually impaired in proper dosage administration insulin.
- Prescription items, on contracts that cover prescription benefits, if the items are determined to be medically necessary:
- Insulin
- Prescriptive medications for the treatment of diabetes
- Glucagon
- Diabetes outpatient self-management training, education and medical nutrition therapy necessary to permit members to properly use the equipment and supplies.

Maternity Benefits / AB38 (1/98)

Coverage will be provided for inpatient maternal health care for a minimum length of stay as follows:

- 48 hours following a normal vaginal delivery
- 96 hours following a delivery by Cesarean Section.

Exceptions to minimum length of stay requirements may be made under certain conditions, including provisions of a follow-up visit within 48 hours of discharge. The decision to discharge the mother and newborn before the mandated timeframes is made by a Santé Community Physicians treating physician in consultation with the mother. A licensed health care provider whose scope of practice includes post partum and newborn care must provide the home healthcare follow up visit.

Members shall receive written notification of their rights under the California State law regarding inpatient hospital length of stay following delivery. This notification of coverage will be provided during the course of her prenatal care.

Continuity of Care/ SB 1129 / SB 1746

Effective January 1, 2004, the State of California and the Department of Managed Health Care implemented a continuity of care law.

Covered services under continuity of care:

- At the member's request, a terminated provider may continue treatment for an acute medical condition and /or serious chronic medical condition (continuity of care for up to 90 days or a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Physician Organization in consultation with the enrollee and the terminated provider and consistent with good professional practice). Examples include, but are not limited to, surgeries scheduled during the first month of transition, ongoing care of home health services, fracture care, cancer care, mental illness, AIDS, CVA/stroke, head injuries, MS, etc.
- At the member's request, a terminated provider may continue treatment for high-risk pregnancy (all trimesters) until completion of postpartum delivery services.
- Terminal illness covered for the duration of the terminal illness.
- Care of a newborn child between birth and 36 months covered for 12 months from the contract termination date.
- Completion of covered services for the Maternal Mental Health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
- Performance of a surgery or other procedure that is authorized as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.
- Behavioral Health care benefits as mandated under California Health & Safety code, mental health parity regulations.
- Extension of Benefits: Must continue to cover, through discharge, inpatient services of a non-plan enrollee if the individual was an enrollee at the beginning of the inpatient stay.

Continuity of care guidelines may apply when:

- A newly covered enrollee member is receiving services from a non-participating provider at the time his or coverage became effective.
- A health care provider is no longer contracting with Santé Community Physicians.

Guidelines for Newly covered enrollees:

For all new enrollees, the health plan will communicate to their members that they must follow the normal, established procedures of their Medical Group in order to receive services.

- New enrollees are provided with "Santé Physicians' Member's Guide." They are advised to call Santé Customer Service with questions related to their medical care.
- Possible COC cases are identified through calls received by the Customer Service department. Members are advised of the continuity of care guidelines. If the member

feels they have a condition that qualifies under these guidelines, they are advised to have their provider contact our UM department to coordinate transition of care.

- The process for continuity of care and completion of services for newly enrolled members receiving services from non-participating practitioner(s) or provider(s) at the time coverage becomes effective with the organization. If not delegated, policy would include statement of referring the member to the health plan as applicable. [Health & Safety Code §1373.95(2)]

Guidelines for terminating contracted providers:

When a primary care practitioner terminates their contract with Santé Physicians, notification is sent to our contracted health plans. Our policy is as follows:

Primary Care Practitioner

- Santé Physicians is to be notified by the primary care practitioner 90 days prior to termination.
- Santé Physicians notifies our contracted health plans of the termination.
- The health plan is responsible for sending a "provider notification termination" letter to their members affected by this change within at least 30 calendar days for Medicare and 60 calendar days for Commercial prior to the effective termination date.
- The members are advised through the health plans letter that Santé Physicians may assist members in selecting a new practitioner.
- In cases where the primary care practitioner notifies Santé Physicians less than 30 days prior to termination, Santé Physicians, the provider and the health plan will discuss the transition of care.

Specialist Termination

- Santé Physicians is to be notified by the terminating specialists 90 days prior to termination
- Santé Physicians notifies the contracted health plans of the termination 90 days prior to the specialist terminating.
- The Provider Group (or specialist) provides written notification to members being seen by a terminating specialist at least 30 calendar days prior to the effective termination date. [CA Health & Safety Code § 1373.65(b)(d), § 1373.96(b)]
- Sante will identify members who have regularly seen the terminating specialist of have an open authorization to receive services from terminating specialist.
- Identified members will be notified by Sante in writing and the notification will be made immediately upon notification of termination, but no later than 60 calendar days prior to the effective date of the specialist's termination.
- Sante Physicians will help members transition to a new specialist within the 'Network".
- DMHC Statutory Required Paragraph [C; HMO, PPO] [CA Health & Safety Code § 1373.65(f)] - All written notices to members concerning specialist terminations must include the following verbatim:

"If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

- All written notices to members must include: Specialist name, Termination status, Effective date of termination, Procedures for selecting an alternate practitioner (e.g.,referring to member/customer service) [Health & Safety Code §1373.65(f)]
- If after sending this notice, the organization reaches an agreement with the terminated provider to renew or enter into a new contract or to not terminate their contract, the organization shall offer affected member the option to return to that provider. This notice may be verbal or written. {Health & Safety Code §1373.65(e)]

Santé Physicians will coordinate with the specialist in transitioning the member's care to a contracted specialist. Continuity of Care coverage will be extended for a longer period if necessary for a safe transfer to another provider.

Santé Physicians retains the same responsibility for review and authorization of services provided by the terminated practitioner in effect prior to the termination (unless otherwise negotiated). The medical management staff of Santé Physicians and the Health Plan will ensure consideration is given to the potential clinical effects that a change in providers would have on a member's health. Members are notified of the review, determination and recommendations, in writing, and the appropriate appeal mechanism in accordance with the standard grievance/appeal process should they disagree with the review decision. Denied COC requests will be processed in accordance with established UM procedures, including MD review/determination and timely written notice of the denial to the member.

Santé Physicians need not consider continuing treatment if the terminated provider voluntarily left the network, does not agree to comply or does not comply with the same contractual terms/conditions in effect prior to termination (unless otherwise negotiated), or was terminated for a medical disciplinary cause, fraud, or other criminal activity.

Santé Physicians is not expected to provide continued access if:

1. The member requires routine monitoring for a chronic condition and is not in an acute phase.
2. Santé Physicians has discontinued the contract based on professional review action based on conduct that affects or could affect adversely the health or welfare of patient(s).
3. The practitioner is unwilling to continue to treat the member of accept Santé Physicians payment or other terms.

Upon request, members have a right to receive copy of Santé Physician's policy.

Coverage for Clinical Trials (SB37, 2001)

Health Plans and PPG's must cover all routine patient care costs related to a clinical trial for a member diagnosed with cancer and accepted for participation in a nationally recognized Phase I, II, III or IV clinical trial for cancer. Copayments and deductibles for services provided in a clinical trail will be the same as for services that are not provided in a clinical trial. Members participating in clinical trials must continue to seek care for primary health care services from their primary care physician (PCP) or specialist. Routine patient care costs mean that costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices and services were not provided in connection with an approved clinical trial.

Routine costs may include:
Regular office visits
Medications
Devices (DME)
Normal radiological or diagnostic testing services
Hospital stays
Services required for the provision of the medication, device or medical treatment being tested in the clinical trial.
Clinically appropriate monitoring of the effects of the medication, device o treatment being tested.
Any reasonable and necessary care for the prevention of complications.

Routine costs would not include:
Medications or devices not approved by the food and drug administration (FDA).
Travel, housing, companion expenses and other non-clinical expenses.
Items or services used solely for data collection and analysis
Health care services customarily provided free of charge by the research sponsors of the clinical trial.

Health and Safety Code section 1370.6 and the Affordable Care Act a customer accepted into a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition, will provide coverage for all routine patient care costs related to the clinical trial when criteria is met.

1. Requests for clinical trials reviewed on a case-by-case basis to determine medical necessity and to assure that the criteria in the law are met. Drugs, items, devices and services will be covered only in trials where the research sponsor (or other party to the clinical trial) does not provide these items or services. When covered, these will be payable as other drugs, items, devices and services are covered absent a clinical trial.

2. Approval for a Qualified Member accepted into a phase I, phase II, phase III, or phase IV eligible clinical trial and will provide coverage for all routine patient care costs related to the clinical trial consistent with the law. (list of eligible trials noted in comment box)

3. A Qualified Member means an enrollee who meets both of the following conditions:
   (A) The enrollee is eligible to participate in an Approved Clinical Trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition; and
   (B) Either of the following applies:
   • The referring health care professional is a participating provider and has concluded that the enrollee's participation in the clinical trial would be appropriate, or
   • The member provides medical and scientific information establishing that the member's participation in the clinical trial would be appropriate.

4. Definition "Routine Patient Care Costs" include drugs, items, devices, and services provided consistent with coverage under the contract for a member who is not enrolled in an Approved Clinical Trial, including the following:

   (A) Drugs, items, devices, and services typically covered absent a clinical trial.
   (B) Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service.
   (C) Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service.
   (D) Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
   (E) Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

5. "Routine Patient Care Costs" does not include the following:
   (A) The investigational drug, item, device, or service itself.
   (B) Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the enrollee.
   (C) Drugs, items, devices, and services specifically excluded from coverage in the contract, except for drugs, items, devices, and services required to be covered pursuant to this section or other applicable law.
   (D) Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

6. Recommendation: Customers who are being considered for enrollment in all clinical trials will be referred to case management. The Case Manager (CM) will coordinate the provision of services with the Medical Group/IPA for capitated services for which the Medical Group/IPA is financially responsible.

Qualifying HIV/AIDS Specialists/AB2168

California HMOs require “standing referrals” for patients with diagnosis of HIV and AIDS. Sante Community Physicians has rostered physicians who meet California Health and Safety Code criteria for an HIV/AIDS specialist. and will be recognized as HIV/Aids providers in addition to their current Sante specialty. They are listed in the Administrative Manual Specialist Physician section under HIV/AIDS. “Standing” or global referrals are to be made for these patients.

Treatment Authorizations/AB 1324

AB 1324 prohibits a health care service plan from rescinding or modifying an authorization after the provider renders the health care service. Santé Physicians has implemented a procedure to identify and manage open authorizations and ensure that the provider's claims are paid appropriately for services provided in good faith when an authorization has been given, but the member is later to be determined to have been ineligible at the time of service.

Mental Health Parity /AB88

As Per SB 946 Santé Physicians will authorize rehabilitative services (physical/occupational and speech therapies) for members, within the guidelines of the member's plan, for patients with a diagnosis of pervasive developmental disorder or autism made by a physician, surgeon or licensed psychologist. When Santé Physicians is not delegated for mental health services, members will be referred to their health plan for any and all behavioral treatment. When Santé Physicians is delegated for mental health services, members will be referred to BBMC for any and all behavioral treatment. Autism Spectrum Disorders (ASD) specific screenings should occur in all children at ages 18 months and 24 months during regular well-child visits at 9, 18, and 24 or 30 months.

Speech Therapy

Speech therapy is included as basic health care services under the Knox-Keene Act. Therefore, any denial must be based upon lack of medical necessity. Denials cannot be based on absence of coverage for such services or based upon lack of physical impairment, or absence of a physical cause for the member's condition, or on the basis that a member does not have a sufficient physical ailment to trigger coverage under clinical guidelines.

Clinically based criteria such as InterQual, MCG and/or other published utilization management criteria for determining the medical necessity of speech therapy may be utilized however, any guidelines must be consistent with DMHC requirements, the Knox-Keene Act and any other applicable California and federal law.

AB1954 Reproductive Health Care Services

Assembly Bill (AB) 1954 adds Section1367.31 to the Health and Safety Code which prohibits, with exceptions, a health plan from requiring a member to obtain a referral prior to receiving reproductive or sexual health care services and applies whether or not the patient is a minor.

Reproductive or sexual health care services, as described in Sections 6925, 6926, 6927, and 6928 of the Family Code, or Section 121020 of the Health and Safety Code, are defined as all reproductive and sexual health care services a member obtains.

OB/GYN SELF-REFERRALS

Members have direct access to participating women's health specialists for routine and preventive health care services provided as basic benefits. In addition, members have the right to self-refer for a screening mammography.

If a member needs obstetrics and gynecology (OB/GYN) preventive care, is pregnant or has a gynecological concern, the member may self-refer to an OB/GYN or family practice physician who provides such services within the member's participating physician group (PPG). If these services are not available within the PPG, the member may go to one of the PPG's referred physicians who provide OB/GYN services. Each PPG must be able to assist members by maintaining a list of its referral physicians. PPG

will arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member's medical needs. The OB/GYN consults with the member's primary care physician (PCP) regarding the member's condition, treatment and needs for follow-up care.

MINOR CONSENT SERVICES

Under California state law, minor consent services are those covered services of a sensitive nature that minors do not need parental consent to access or obtain. The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. Minors under age 18 may consent to medical care related to:

- Prevention or treatment of pregnancy (except sterilization) – California Family Code (CFC) §6925.
- Family planning services, including the right to receive birth control – CFC §6925.
- Abortion services (without parental consent or court permission) – American Academy of Pediatrics (AAP) v. Lungren, 16 Cal. 4th 307 (1997).
- Sexual assault, including rape diagnosis, treatment and collection of medical evidence. However, the treating provider must attempt to contact the minor's parent or legal guardian and note in the minor's treatment record the date and time of the attempted contact and whether it was successful. This provision does not apply if the treating provider reasonably believes that the minor's parent or guardian committed the sexual assault on the minor or if the minor is over age 12 and treated for rape – CFC §6927 and CFC §6928.
- HIV testing and counseling for children ages 12 and older – CFC §6926.
- Infectious, contagious, communicable, and sexually transmitted diseases diagnosis and treatment for children ages 12 and older – CFC §6926.
- Drug or alcohol abuse treatment and counseling for children ages 12 and older, except for replacement narcotic abuse treatment – CFC §6926(b).
- Outpatient behavioral health treatment or counseling services for children ages 12 and older under the following conditions:
    - In the opinion of the attending provider, the minor is mature enough to participate intelligently in the outpatient or residential shelter services.
    - The minor would present a danger of serious physical or mental harm to himself or herself or to others without the behavioral health treatment, counseling or residential shelter services, or is the alleged victim of incest or child abuse – CFC §6924.
    - Skeletal X-ray – A health care provider may take skeletal X-rays of a child without the consent of the child's parent or legal guardian, but only for the purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the abuse or neglect – Cal. Penal Code CFC §11171.
- General medical, psychiatric or dental care if all of the following conditions are satisfied:
    - The minor is age 15 or older.

- The minor is living separate and apart from his or her parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence.
- The minor is managing his or her own financial affairs, regardless of the source of the minor's income. If the minor is an emancipated minor, he or she may consent to medical, dental and psychiatric care – CFC § 6922(a) and§ 7050(e).

Health care coverage: State of Emergency

As of 1/1/2019 California Requirement – Section 1368.7 Health and Safety Code defines that delegate will provide members who have been displaced, or with a potential to be displaced, by a state of emergency, access to medically necessary health care services within 48 hours after the emergency has been declared by the Governor. The delegate operating in the county or counties included in the declaration must file with the department a notification describing whether the delegate has experienced or expects to experience any disruption to the operation, explaining how the delegate is communicating with members, and summarizing the actions the delegate has taken or is in the process of taking to ensure that the health care needs of members are met.

This may require the following actions, including, but not limited to, the following:

1. Relax time limits for prior authorization, precertification, or referrals
2. Extend filing deadlines for claims.
3. Suspend prescription refill limitations & Allow an impacted enrollee to refill his/her prescriptions at an out-of-network pharmacy.
4. Authorize enrollee to replace medical equipment supplies.
5. Allow enrollee to access an appropriate out-of-network provider if a Network provider is unavailable due to the state of emergency or if the enrollee is out of the area due to displacement.
6. Have a toll-free phone number that enrollee may call for answers to questions, including questions about loss of health insurance ID cards, access to prescription refills, or how to access health care.

CMS Final Rule for DSNP Reasonable Assistance

The Centers for Medicare & Medicaid Services (CMS) Final Rule for 2020 states that dual special needs plans (DSNP), including Fully Integrated Dual Eligible Special Needs Plan (FIDE) and Highly Integrated Dual Eligible Special Needs Plan (HIDE), need to coordinate delivery of Medicare and Medicaid services. This may include coverage of Medicaid services such as Long-Term Services and Supports (LTSS) and behavioral health.

The CMS Final Rule is meant to better serve members in the following areas.

- **Coordination:** Integration between programs
- **Experience:** Improve quality, predictability and responsiveness

- **Engagement:** Bring the situation to resolution with collaboration
- **Performance:** Increase productivity and efficiency through improved processes

Ensure members' appropriate care coordination, all Medicare and Medicaid organizations are required to comply with the CMS Final Rule. Transfer DSNP members to Health Plan Customer Service in order to provide:

- Reasonable assistance with filing grievances and requesting appeals
    - Reasonable assistance implies what can and should be done in the context and purpose of the CMS Final Rule – without requiring a party to leave no stone unturned.
- Reasonable assistance with resolving coverage and authorization issues
    - Act according to what is reasonable in view of the particular nature of the request and the circumstances involved, in particular, the interests and expectations of the member.
- Assistance and information on Medicaid-covered service(s) when aware of a member's need
- Coordinated delivery of Medicaid benefits for individuals who are eligible for such services

ERISA

A statement of the members right to bring a civil action may include the following:

You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if you are enrolled with your Health Plan through an employer who is subject to ERISA. First, be sure that all required reviews of your claim appeal have been completed and your claim has not been approved. Then consult with your employers benefit plan administrator to determine if your employers benefit plan is governed by ERISA. Additionally, you and your Health Plan may have other voluntary alternative dispute resolution options, such as mediation.

Diagnosis/Treatment Codes

"Member can obtain, upon request, a written statement describing the availability of diagnosis and treatment codes and their corresponding meaning."

Consumer Resources

A statement of additional consumer resources may include

"Other resources to help you: Do you have questions about your appeal rights or this notice? Need help with an appeal? You can get help from the Consumer Assistance Program (CAP) in California.

California Department of Managed Health Care Help Center

Toll Free: 1-888-466-2219 TDD/TTY 1-877-688-9891

http://www.healthhelp.ca.gov"

All-Plan Letters (APL) Medi-CAL

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 16-013, 20-018, Transgender Beneficiaries

The Insurance Gender Nondiscrimination Act (IGNA) prohibits discrimination against individuals based on gender, including gender identity or gender expression (Health and Safety Code Section (§)1365.5). The IGNA requires that Medi-CAL Managed Care Health Plans (MCP's) (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 § 92.207(b)(4)).

The following are considered core services in treating gender dysphoria:

i). Behavioral Health services
ii). Psychotherapy
iii). Hormone Therapy, and

A variety of surgical procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender.

- All Medi-Cal covered services that are provided to non-transgender members will be provided to members who have been diagnosed with gender dysphoria, so long as the services are medically necessary or meet the definition of reconstructive services.
- Nationally recognized medical/clinical guidelines will be used to review requested services from transgender members and those standards shall apply consistently across the population. Health Plan UM Guidelines and Medical Policies will be the primary source.
- The determination of whether a service requested by a transgender member is medically necessary and/or constitutes reconstructive surgery must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the member's primary care provider.
- All medically necessary services and/or reconstructive surgery that are otherwise available to non-transgender members will be provided timely. Services will not be limited and will the frequency of services will not be limited.
- MCPs (and subcontractors) are required to provide members who have been diagnosed with gender dysphoria with all Medi-Cal covered services that are provided to non-transgender members, so long as the services are medically necessary, or meet the definition of reconstructive surgery. Medical necessity and/or reconstructive surgery determinations must be made on a case-by-case basis. Organization may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determinations, and/or apply appropriate utilization management criteria that are non-discriminatory.
- MCPs (and subcontractors) are not required to cover cosmetic surgery. Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance" (Health and Safety Code § 1367.63(d)).
- When issuing a Notice of Action letter (NOA) for clinical reasons not meeting medical necessity, it must use language that supports the denial both on the

basis of not medically necessary to treat gender dysphoria and does not satisfy the criteria of the reconstructive surgery statute.

APL 18-013 Hepatitis C Virus Treatment

The purpose of All Plan Letter (APL) 18-013 is to notify all Medi-Cal managed care health plans (MCPs) of the Department of Health Care Service's (DHCS) new policy for the treatment of the hepatitis C virus (HCV). The new policy, titled "Treatment Policy for the Management of Chronic Hepatitis C,"[1] was put into effect July 1, 2018, and replaced the hepatitis C policy that was previously released in July 2015.

This policy updates the criteria for identifying treatment candidates and outlines several requirements and recommendations for the treatment of beneficiaries with HCV. MCPs may operationalize requirements and recommendations in different ways as long as utilization management protocols are medically reasonable and do not unnecessarily impede access to treatment.

- Santé Physicians will utilize the guidelines set forth in the Treatment Policy for the Management of Chronic Hepatitis C
- Utilization management protocols are medically reasonable and do not unnecessarily impede access to treatment.
- Santé Physicians informs contracted practitioners of requirement to utilize guidelines
- Santé Physicians provides contracted practitioners with access to the All Plan Letters (APL) and guidelines found on the Santé Medi-CAL website.

[1] "Treatment Policy for the Management of Chronic Hepatitis C" is available at: http://www.dhcs.ca.gov/Pages/HepatitisC.aspx.

APL 18-014 ALCOHOL MISUSE

Santé Physicians are 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 Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care. The USPSTF recommends that clinicians screen adults ages 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

Policies and Procedures:

1. Providers will use one of these validated screening tools when screening members for alcohol misuse:
   - The Alcohol Use Disorders Identification Test (AUDIT);

- The abbreviated AUDIT-Consumption (AUDIT-C); and
- 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. Contracted practitioners can find the requirement (APL 18-014) to include screening & Behavioral Counseling Interventions on the Santé Medi-CAL website.
3. Contracted practitioners can find screening tools within (APL 18-014) on the Santé Medi-CAL website.
4. Members who, upon screening and evaluation, meet the criteria for an AUD as defined by the current DSM (DSM-5, or as amended), or whose diagnosis is uncertain, are referred for further evaluation and treatment to the county department for alcohol and substance use disorder treatment services, or a DHCS-certified treatment program.
5. Providers in primary care settings offer and document alcohol misuse screening services will be documented within patient's chart.

APL 18-006 BEHAVIORAL HEALTH TREATMENT

Behavioral Health Treatment (BHT) is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement or through prompting to teach each step of targeted behavior. BHT services are designed to be delivered primarily in the home and in other community settings.

BHT services are a Medi-Cal covered benefit for members under 21 years of age when medically necessary, based upon the recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of autism spectrum disorder (ASD).

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

Santé Physicians informs contracted practitioners about:

- BHT services
- Eligibility criteria
- Referral
- Anthem Resources

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.

APL 20-012 Private Duty Nursing Case Management Responsibilities For Medi-CAL Eligible Members Under the Age of 21

POLICY:
Medi-CAL managed care health plans (MCP) are contractually obligated to provide case management services to members. Specifically, for Medi-Cal eligible members under the age of 21 who have had Private Duty Nursing (PDN) services approved, MCPs are required to provide case management, as set forth in the MCP contract, and to arrange for all approved PDN services, whether or not the MCP is financially responsible for the PDN services.

If the MCP is the entity that approved the PDN services for an eligible member under the age of 21, the MCP is primarily responsible for providing case management to arrange for all approved PDN service hours. If another entity, such as CCS, has authorized PDN services and is primarily responsible for providing case management for those PDN services, MCPs must still provide case management as necessary, including, at the member's request, arranging for all approved PDN services. MCPs must use one or more Medi-Cal enrolled Home Health Agency (HHA)s or individual nurse providers, or any combination thereof, to meet the member's approved PDN service needs.

PDN Case Management Responsibilities
When an eligible member under the age of 21 is approved for PDN services and requests that the MCP provide case management services for those PDN services, the MCP obligations include, but are not limited to:

- Providing the member with information about the number of PDN hours the member is approved to receive;
- Contacting enrolled HHAs and enrolled individual nurse providers to seek approved PDN services on behalf of the member;
- Identifying potentially eligible HHAs and individual nurse providers and assisting them with navigating the process of enrolling to become a Medi-Cal provider; and
- Working with enrolled HHAs and enrolled individual nurse providers to jointly provide PDN services to the member.

Members may choose not to use all approved PDN service hours, and MCPs are permitted to respect the member's choice. MCPs must document instances when a member chooses not to use approved PDN services. When arranging for the member to receive authorized PDN services, MCPs must document all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.

SANTÉ PHYSICIANS IPA

Policy/Procedure

LANGUAGE ASSISTANCE PROGRAM (LAP)

Policy: 2.03.5
Origination Date: 01/2009
Last Review Date: 01/2024

Purpose:
Santé Physicians will cooperate and comply with all contracted health plans in the health plan's obligation to provide language assistance services to Limited English Proficient (LEP) HMO members in accordance with Title 28, California Code of Regulations, 1300.67.04 and applicable revisions to the Knox Keene Act.

Policy:
1. Interpretation Services – the act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).

   Santé Physicians is not delegated to provide interpretation services. If an LEP member or the member's representative contacts Santé Physicians administrative offices or customer service either in person, via the telephone, or electronic via web/video, (if available) the Santé Physicians staff at the encounter will inform the member of their right to interpretive services and auxiliary aids at no cost and follow the applicable workflow for the contracted health plan's interpretive services**.**

2. Notice of LAP Translation Services -
   Although not delegated to provide LAP services, Santé Physicians is delegated to issue certain Utilization Management and Claims documents that fall within the scope of the regulations. The contracted health plans will provide a DMHC approved notice of translation services in the appropriate threshold languages; this notice must accompany the following Santé Physicians produced non-standardized vital documents when issued in English:
   a. UM denial notifications, including denial, modification or delay in service
   b. UM delay notifications for additional information or expert review
   c. Claims denial notifications (e.g. member liability letters or those that require a response from the member)
   d. Specialist termination letters to members

3. Requests for Translation
   Santé Physicians is not delegated to provide translations of non-standardized vital documents. However, Santé Physicians will forward requests received from members to the contracted health plan in a timely manner. Santé Physicians also will provide

copies of non-standardized vital documents as described in section II above to the health plan upon request in a timely manner (see procedure section 2.a for timeliness standards).

Objectives:

1. When requested by the LEP member, to assist LEP members access to the contracted health plan interpreter services at Santé Physicians customer service or other administrative services (either telephonic, in person, or electronic via web/video, if available)
    a) Point of contacts to include:
        - Administrative offices
        - Contracted PCP offices
        - Contracted SCP offices
        - Contracted ancillary providers
        - Centralized appointment line
        - After hours line
        - Telephone advice line with licensed health professional
        - Other
2. To include the contracted health plan offer of translation services when the following non-standardized vital documents are administered in English to LEP members by Santé Physicians:
    - UM denial, modification or delay in service letters
    - UM delay letters
    - Claims denial letters (e.g. member liability letters or those that require a response from the member)
    - Specialist Termination Letters to Members
3. To forward requests for translation to the contracted health plan in a timely manner.
4. To forward non-standardized vital documents to the contracted health plan for translation when requested by a LEP member, and in a timely manner.
5. To respond to the contracted health plan's request for information related to LAP services or LEP member complaints.

Procedure:

1. Offer of Translation Services
    a) Notice to Accompany Non-Standard Vital Documents
    Contracted health plans will provide Santé Physicians with an approved notice of translation services, which should accompany non-standard vital documents that are produced in English to LEP members by Santé Physicians. To ensure the required information is provided, the person(s) responsible for the creation of member notifications will:
    - Ensure the member's health plan is correctly identified.
    - Ensure that the health plan's approved notice is attached to:
        - Service denial letters, including those which modify services or create a delay in delivery;

- Delay or pend letters;
- Claims denial notifications (e.g. member liability letters or those that require a response from the member)
- Specialist Termination Letters

- Either: Maintain a copy of the notice with the applicable referral or claims file for review by health plan auditors; Or: Demonstrate to health plan auditors that the Notice is included when non-standard vital documents are administered to LEP members in English.

NOTE: To avoid corruption by word processing systems, notices in languages other than English will be provided by the contracted health plans in either PDF or image format.

2) Requests for Translation

a) Member Request for Translation of Non-Standardized Vital Document

When a member request for translation is received by Santé Physicians, the staff member receiving the request will:

- Access the health plan interpreter services to facilitate communication with the LEP member as outlined under Section I.
- Document the time and date of the request.
- Confirm the document that needs translation using referral number or other applicable specific identification.
- Forward the request and the requested document to the contracted health plan (track date and time) within the timeframes as follows:
- Timeliness standards are necessary to ensure that the requested document is translated within the 21 calendar days as required by the regulations. Santé Physicians will forward the member request to the Health Plan within the following timeframes:
  - Urgent request or service: One business day
  - Non-urgent or post-service request: Two business days

NOTE: The health plan is solely responsible for the decision to provide written translation.

b) Health Plan Requests Copy of Non-Standardized Vital Document

When Santé Physician's staff receives a request for a copy of document issued by Santé Physicians in accordance with UM or Claims delegation processes, the staff will:

- Document the date and time of the request.
- Return the requested documents to the contracted health plan within the timeframes listed in section III.A.

c) Member Request for Translation of Health Plan Produced Vital Document

When Santé Physicians receives a request for the translation of a health plan produced vital document, the Santé Physicians staff will:

- Forward the request to the contracted health plan within the timeframes listed in section 2.a.

3) Training and Education
   a) Santé Physicians LAP Staff Training and Education

   As required by the regulations, each contracted health plan will distribute LAP staff training and education materials regarding the health plan's LAP services, cultural competency, cultural sensitivity and effective use of interpreters. Santé Physicians is expected to ensure that all staff who is in contact with LEP members receives these materials through formal or informal processes. The person responsible for staff education and training will:

   - Assemble the materials by health plan.
   - Distribute or make available to all applicable staff either by:
     - Staff newsletters
     - Staff meetings
     - Intranet, Internet or e-mail
     - Other

Santé Physicians will provide evidence of distribution or availability of health plan LAP staff training and education materials to the contracted health plan upon request.

Definition of Lap Terms:

1. Demographic profile means, at a minimum, identification of an enrollee's preferred spoken and written language, race and ethnicity.
2. Limited English Proficient or LEP Enrollee: an enrollee who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees.
3. Threshold Language(s): the language(s) identified by a plan pursuant to Section 1367.04(b)(1)(A) of the Act.
4. Vital Documents: the following documents, when produced by the plan (plan-produced documents) including when the production or distribution is delegated by a plan to a contracting health care service provider or administrative services provider:
   (A) Applications;
   (B) Consent forms, including any form by which an enrollee authorizes or consents to any action by the plan;
   (C) Letters containing important information regarding eligibility and participation criteria;
   (D) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal;
   (E) Notices advising LEP enrollees of the availability of free language assistance and other outreach materials that are provided to enrollees;
   (F) A plan's explanation of benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee; and
   (G) Subject to subsection (c)(2)(F)(ii), the enrollee disclosures required by Section 1363(a)(1), (2) and (4) of the Act. (CCR 1300.67.04(c)(2)(F) A requirement that, with respect to vital documents that are not standardized, but which contain enrollee-specific information, a plan shall provide the English

version together with the Department-approved written notice of the availability of interpretation and translation services and, if a translation is requested, the plan shall provide the requested translation in accordance with the requirements of Section 1367.04 of the Act and this section.

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT FOCUS STUDIES

Policy: 2.04
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The UM staff will assist in the process of conducting focus studies as requested. It is a requirement of the Utilization Management Program that tracking and trending of utilization take place in order to continually enhance the appropriate, cost-effective high quality care delivered to the members of the Santé Physicians IPA. New medical technologies and the applications of established technologies including medical procedures, drugs, and devices also are studied and evaluated.

Policy:

1. UM staff will be involved in the tracking and evaluation of particular aspects of the UM program.

2. UM reports will be generated and reviewed for accuracy by the UM staff.

3. The reports will be presented to the Utilization Management Committee for analysis, as requested.

4. The UM Committee then may ask the staff to conduct a focus study (see Focus Study Format), which is specifically relevant to the Santé Physicians IPA's membership, and has a direct affect on improving healthcare

5. Providers and other appropriate professionals are involved in developing the evaluation criteria for the studies, especially in regard to the technological studies.
    a. Criteria are based on a review of information obtained from government regulations and reputable empirical evidence.
    b. The criteria are used effectively to evaluate
        - New technologies and various applications of existing technologies.
        - New and existing programs and practices

6. The UM Committee will analyze the study results and make recommendations for change based on their findings.

7. The UM Committee will be given follow-up reports so that the affects of the changes may be evaluated.

Procedure:

1. The Utilization Management staff will obtain data requested for reports.

2. The requested reports then will be produced for the UM Committee meetings/designated meeting.

3. If a focus study is conducted, the UM staff will assist in the data gathering and study process.

4. The results of the studies and the UM Committee recommendations will be shared with the UM staff and providers.

5. The UM staff will assist in the implementation of recommended change and also in the follow-up evaluation process.

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT FOCUS STUDY FORMAT

Policy: 2.05
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The UM staff follow a consistent focus study process and assist in the accurate evaluation and enhancement of the Santé Physicians IPA's Utilization Management Program.

Policy:

The UM staff will be trained to follow a consistent process when gathering data for focus studies and reports. Accuracy of the data collection and ability to follow the approved data gathering process will be part of the staff member's/decision support's job evaluation.

Procedure:

Studies approved by the Utilization Management Committee will be conducted by the UM staff.

The following is the format utilized in the focused study process:

1. Title - The title will succinctly represent the focus study.

2. Objective - The defined objective for the planning, preparation, conduction, and documentation of the review process will be clearly stated.

3. Description - The description of the focus study will include:
   - Important areas of concern (e.g. over utilization, under utilization, inappropriate utilization, high risk cases, member/provider satisfaction, new technology)
   - Identification of indicators - outcomes, processes, structures
   - Thresholds for evaluation
   - Assignment of responsibility
   - Delineation of the scope of services

4. Comparative Studies/Regulations - Information obtained from a review of comparative studies as well as acknowledgment of governmental and other applicable regulations will be included.

5. Study Period - The time period will be defined during which the focus study will be conducted.

6. Methodology - The data collection methods will be described, including:
   - Data sources
   - Sampling
   - Frequency

7. Population or Sample Size - An adequate sample size or population will be defined and utilized in the study.

8. Summary of Findings
   a. The results of the study will include information about the involved facilities, providers, departments, technologies, or systems.
   b. Significant or quality-related issues will be identified and brought to the attention of the Quality Improvement Committee.
   c. A conclusion will be drawn from the results of the study.

9. Utilization Management Committee Impressions
   a. The UM Committee will determine whether a significant problem exists and will give recommendations for corrective action.
   b. The UM Committee will determine whether a new technology or method of practice is appropriate and will recommend a plan for education and implementation.

10. Plan and Actions - The action plan will be implemented.

11. Follow-up and Re-evaluation
   a. The follow-up actions will include education and the completion of a list of study topics that surfaced as a result of the study.
   b. A re-evaluation study will be conducted within the time frame designated by the Utilization Management Committee.

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT REVIEWER TESTING

Policy: 2.06
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The Santé Physicians IPA conducts periodic tests on all Utilization Management staff involved in the actual utilization review process. The purpose of the evaluations is to measure the reviewer's comprehension of the clinical practice guidelines and to ensure accurate and consistent application of the criteria among the reviewers.

Policy:

The UM staff will be tested on their knowledge and appropriate application of the Santé Physicians IPA approved clinical practice guideline criteria:

1. Prior to the end of their probationary period as a new employee.
2. Quarterly or Annually after their initial evaluation.

Other health care professionals will be evaluated annually according to policy and procedure. Performance improvement activities (education & training) will be implemented and re-evaluations conducted as needed.

Procedure:

1. Measurement tools, which assess reviewer interpretation and consistent application of the clinical practice guidelines, will be developed and approved by the Utilization Management Committee.

2. The testing process and measurement tools will be shared with the Santé Physicians IPA's contracted Health Plans.

3. The Director of Utilization Management/Healthcare Services will conduct or delegate the responsibility of conducting reviewer tests.

4. The staff will be tested in the areas of:
   a. Referral and authorization policies (including specialty care, in-office procedures, rehabilitative, DME, and outpatient services).
   b. Inpatient hospital, skilled nursing facility, and home health/hospice admissions.

5. If reviewer performance is not satisfactory mandatory training will follow and re-evaluation (test) will be conducted.

Non-Clinical Staff Testing Methods:

Testing methods that may be utilized including but not limited to:

a. Telephonic Evaluation - the evaluator will listen in on utilization review telephone calls. This evaluation will be done randomly over a two week period and will include a pre-designated number of calls to be tested (depending on the size of the Santé Physicians IPA membership).
b. Mock Cases - the evaluator will utilize case studies that simulate actual clinical situations. The cases will be presented, and for each case the staff member will give an appropriate description of the application of the criteria and a complete review process.
c. Staff Member Documentation - the evaluator may actually look at the documented clinical information submitted by the providers (and that which has been accumulated by the UM staff) and match it to the criteria applied by the staff member.

Clinical Staff (R.N./M.D.) Testing Methods:

Testing methods that may be utilized including but not limited to:

a. Mock Cases - the evaluator will utilize case studies that simulate actual clinical situations. The cases will be presented, and for each case the staff member will give an appropriate description of the application of the criteria and a complete review process.
b. Staff Member Documentation - the evaluator may actually look at the documented clinical information submitted by the providers (and that which has been accumulated by the UM staff) and match it to the criteria applied by the staff member.

Note: The testing methods described above (a, b, c,) may be used sequentially for evaluating staff as their level of experience increases.

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT INTER-RATER RELIABILITY

Policy: 2.07
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The Utilization Management (UM) Program is designed to monitor, evaluate, and manage the cost and quality of healthcare services delivered to all members in a consistent manner.

Policy:

There will be a standard utilization management criteria used to assess the appropriateness of specific health care decisions, services, outcomes, and how participating practitioners are involved, educated, and compliant with policies and procedures.

Procedure:

The following is the concurrent review process:

a) Inter-rater reliability activities will be performed on physician, non-physician, and non-clinical reviewers.

b) NCQA "8/30 methodology will be utilized to assess consistency with which physician, non-physician, non-clinical reviewers apply UM criteria.

c) The UM Committee will quarterly perform inter-rater reliability chart reviews for M.D and Clinical Reviewers to assess for consistency, management and appropriateness of criteria and decision making.

d) The Medical Director will perform inter-rater reliability chart reviews quarterly for R.N. Clinical Reviewers. Clinical staff will perform inter-rater reliability chart review annually for non-clinical staff. The chart reviews will be performed to assess consistency, management and appropriateness of criteria and decision making.

e) Results of chart reviews will be logged and maintained to track performance with a benchmark of 90%.

f) The UM Committee will be given the results Quarterly for clinical reviewers and annually for non-clinical staff Inter-rater reliability reviews.

g) Necessary corrective action will be taken, if applicable. Scoring of reviews will be provided back to all reviewers to increase performance, consistency, and appropriateness of criteria and decision making skills with a goal of 90% threshold.

SANTÉ PHYSICIANS IPA

Policy/Procedure

PRIMARY CARE PHYSICIAN RESPONSIBILITIES

Policy: 2.08
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The Primary Care Physician (PCP) is responsible for providing or overseeing comprehensive healthcare services for Santé Physicians IPA members. The responsibilities of the PCP are defined for the purpose of assisting the Santé Physicians IPA staff and providers in understanding the scope of the primary care practice within the Santé Physicians IPA.

Policy:

1. A Primary Care Physician "job description" will be developed to assist the Santé Physicians IPA staff and providers in understanding the definition of the PCP's role. This job description will recognize the Santé Physicians IPA approved practice guidelines.

2. The contracted Primary Care Physician agrees to comply with the Santé Physicians IPA's Utilization Management Program.

3. Primary Care Physicians are notified of their responsibilities in the contractual service agreement that they sign to become a provider of the Santé Physicians IPA. Any changes will be handled through the Santé Physicians IPA's governance structure as described in the agreement.

Scope:

Established descriptions of Primary Care Physician responsibilities may be reviewed, approved and utilized by the Santé Physicians IPA. The Santé Physicians IPA also may develop its own description of the Primary Care Physician responsibilities. The following describes in general the role of the primary care physician:

1. The PCP serves as the provider and general manager (commonly referred to as the "manager") of the member's care. As the focal person of contact, the PCP functions as a resource and consultant for all healthcare services provided to the member.

2. The PCP or Santé Physicians IPA contracted primary care physician provides 24-hour/seven day per week coverage for the PCP's primary care practice.

3. The PCP evaluates specialist consult summaries and determines (with specialist provider input) whether additional specialty services are needed. Including forwarding copies of medical records or test results to the specialist. This involvement of the PCP helps to ensure continuity of care while at the same time it eliminates duplication of services.

4. The PCP submits authorization requests (for necessary services) to the UM Committee for approval.

5. The PCP works with the (CMO/Medical Director)/ Physician Utilization Management designee or the Utilization Management Committee to justify the authorization of appropriate services for Santé Physicians IPA members.

6. Primary Care Physicians are expected to provide certain services to members without referral to a specialist unless treatment modalities listed in the PCP "job description" have been conducted without a significant improvement in the member's condition.

7. During the member's hospitalization, skilled nursing facility, or home healthcare, the PCP continues to monitor the medical necessity of services being provided and facilitates the appropriate transfer of the member to the next lower level of care at the earliest opportunity and coordinates with the attending physician when specialist consultations and services are needed during an inpatient stay. Alternatively, an attending physician may be responsible for monitoring the member's care.

8. The PCP provides medical expertise and direction concerning the members' healthcare needs while promoting the success of the Santé Physicians IPA.

Primary Care Physician Job Description

The primary care physician description of responsibilities will include but not be limited to the following:

i) Routine office visits, related physician care and after-hours care of uncomplicated medical problems.
ii) Periodic health evaluations which are appropriate and timely for all adults and children who are members of the PCP's practice.
iii) Immunization/injections for adult and children members.
iv) Well-child care.
v) Twenty-four hour on-call coverage.
vi) Consultation time to manage the member's care.
vii) Visits and examinations in the emergency room, hospital, skilled nursing facility, or extended care facility.

viii) Home visits and supervision of the home healthcare regimen.

ix) Referral of members to appropriate specialty providers or ancillary services as medically necessary and according to Santé Physicians IPA approved practice guidelines for referrals and note the referral in the patient's medical record.

SANTÉ PHYSICIANS IPA

Policy/Procedure

OBSTRETRICIAN/GYNECOLOGIST AS PRIMARY CARE PHYSICIANS

Policy: 2.08A
Origination Date: 02/2011
Review Date: 01/2024

Purpose:

To include obstetrician/gynecologists as eligible primary care physicians provided they meet the plan's eligibility criteria for all specialists seeking primary care physician status.

Policy:

Santé Physicians will include obstetrician/gynecologists as eligible primary care physicians. Santé Physicians will establish reasonable requirements for the participating obstetrician/gynecologist seeking primary care physician status.

Scope:

1. Santé Physicians shall allow an enrollee the option to seek primary care physician services directly from a participating obstetrician/gynecologist.
2. Santé Physicians has established reasonable requirements for the participating obstetrician/gynecologist to practice as a primary care physician. Santé Physicians requires that the obstetrician/gynecologist seeking primary care physician status meet the definition/expectations as defined in § 14254 of the Welfare and Institutions Code as follows. The term "primary care physician" means a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.
3. Santé Physicians requires the participating obstetrician/gynecologist to fulfill their contractual obligations as a primary care provider.

Reference Sources:

CA Health & Safety Code § 1367.69
CA Welfare & Institutions Code § 14254
Department of Managed Health Care Director's Letter 1-K, February 18, 2010, http://dmhc.ca.gov/library/reports/news/dlk1.pdf

SANTÉ PHYSICIANS IPA

Policy/Procedure

COMMUNICATION DEFICITS / INTERPRETERS/ AUXILIARY AIDS

Policy: 2.09
Origination Date: 07/2002
Last Review Date: 01/2024

Purpose:

To provide communication assistance as needed for persons with impaired hearing, speech, and/or blind, vision loss or deaf-blind deficits and to provide physicians offices with guidelines for the use of interpreters/translators.

To define the process of providing equal opportunities for communication to patients with disabilities in accordance with the Americans with Disability Act (ADA), Title VI of the Civil Rights Act (1964) and section 504 of the Rehabilitation Act (1973) and to comply with all regulatory requirements.

Policy:

Santé Physicians are committed to the policy of provision of services to all members with or without disabilities. In the instance the member requires communication assistance, it is expected that the physician and/or office staff will provide the means for communication when considered essential. Such means are intended to provide the member with equal opportunities for communication as afforded to non-disabled patients. Provider will evaluate member's individual need to determine which aid should be provided. Communication between the Physicians and the member must be sufficiently clear and understandable so that necessary medical care may be delivered.

Procedure:
Santé Physicians and their office staff will be familiar with the provision of service to the handicapped. Information related to the provision of service is updated as necessary. Education of Office staff is an ongoing process and reviewed periodically.

The member's primary language and/or hearing or speech impairment are to be noted in the medical record/chart. Medical record will also contain documentation of member's ability to communicate and communications devices required for assistance.

If the member refuses the assistance of an interpreter and indicates that they prefer to have a family member assist with communication, documentation of this should be included in the medical record.

Claims can be paid when services are required.

Interpreters

1. Bi-lingual office staff or family members may serve as interpreters. Community Interpreter services may also be utilized such as "The Language line".

   Note: The member may choose to use a family member or friend whom volunteers to interpret. Use of a minor as an interpreter is discouraged except in the case of emergency care.

Deaf or Speech/Hearing Impaired

1. The following may be provided or arranged as necessary for deaf or hearing impaired members:
   - Writing utensils, letter board, and slate.
   - Picture board so member can communicate by pointing if unable to write.
   - Community Interpreter services may also be utilized such as Deaf and Hard of Hearing Service Center, (DHHSC).
   - For TDD/TTY use California Relay 711 and CCTV devices may be utilized but need for device must be identified before office services are provided to allow for procurement and installation of device.

Blind

1. For people who are blind, have vision loss, or are deaf-blind, this includes providing a qualified reader: information in large print, Braille, or electronically for use with a computer screen-reading program; or an audio recording of printed information. A "qualified" reader means someone who is able to read effectively, accurately, and impartially, using any necessary specialized vocabulary.

SANTÉ PHYSICIANS IPA

Policy/Procedure

EMERGENCY SERVICES

Policy: 2.10
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The UM staff will assist providers and members to follow the proper emergency department service utilization process which is aimed at the appropriate authorization of emergency department services.

Policy:

Utilization Management staff will provide guidance to providers and members regarding emergency department service utilization.

Procedure:

The UM staff receives (or places) calls regarding emergency department service authorizations from Santé Physicians IPA contracted providers, emergency department staff, and members. These calls may be made regarding service authorizations at a contracted facility, a non-contracted facility, or an out-of area non-contracted facility.

The following is the UM staff's emergency department service guidance and data gathering process:

1. If the situation involves the need for immediate emergency care, the member is advised to go to the closest Emergency Facility.

2. Emergency services are authorized for all services required for the stabilization of the member unless,
   - the Health Plan reasonably determines that emergency services were not rendered; or
   - the member did not require emergency services and the member should have reasonably known that an emergency did not exist. (refer to #13 'Prudent Layperson' definition.)

3. Post stabilization care will be provided for medically necessary, non-emergency services needed to ensure that the patient remains stabilized from the time the treating hospital requests authorization until the time the patient is discharged of a contracting

medical practitioner agrees to other arrangements. (Balanced Budget Act (BBA) §422.100, federal Register 34986, H & S Code §1371.4(a), Title 10, CCT Sec. 1300.71.4)

4. During office hours, Santé UM Coordinators will accept calls regarding requests for authorization of ER services, document the specifics, and refer the caller to the patient's Primary Care Physician.

5. Santé does not require prior authorization for emergency services. When a PCP or Specialist who referred a patient to the emergency room for services notifies Santé, Santé UM will issue an authorization for those services and note the MD referral information. Out of area pre-service requests will be referred to the health plan or health plan's senior services.

6. The Primary Care Physician may refer the subscriber/member to his/her office, another Primary Care Physician, in-plan specialists (see Referrals), or to a Santé contracted Urgent Care Center or Emergency Room facility as the situation indicates.

7. When the Primary Care Physician or authorized representative of Santé Community Physicians Santé Physicians IPA refers the subscriber/member to the ER as medically indicated based on the information available at the time, the participating medical group is obligated to authorize payment by the HMO. The same applies if the Primary Care Physician is contacted by the ER facility and the Primary Care Physician does not redirect the patient to another provider.

8. Should the medical record clearly not indicate appropriate use of the ER based on criteria approved by the Utilization Management Committee, and there is no documentation of Primary Care Physician referral to the ER, the claim will be denied as inappropriate use of the ER.

9. Denial decisions (including psychiatric) will include consideration of presenting symptoms not be based solely on discharge diagnoses.

10. Appropriate services and care shall not be discontinued until the members treating/attending provider has been notified of the PMG's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical need of the member. (see Service Denials Policy 2.15)

11. Denials of emergency services will be documented and maintained in accordance with UM department policies regarding service denials. The patient and/or facility may appeal as specified in the denial letter. Skilled therapy service requests (SNF, HH, OT/PT/ST) are not denied based on the absence of potential for improvement or restoration. Requests are reviewed based on member's medical condition and requirement of skilled care that is reasonable and necessary to prevent or slow further deterioration.

- *Restoration potential of a member may not be the deciding factor in determining whether skilled services are needed.*
- *Skilled therapy services are covered when an individualized assessment of the member's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program*.

12. Claims for emergency services and /or emergent ambulance services are reviewed by clinician(s) in the Utilization Management Department. The Medical Director reviews denial of services. Upon approval, the clinician(s) indicate same on the claim, date and time; then forward for payment.

13. According to SB1832 emergency services cannot be denied for lack of authorization. Services are to be considered an emergency if: "….In the judgement 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 bodily organ or part." Emergency services for ambulance transport fall within the coverage guidelines of SB1832. A member is considered to have acted "reasonably" if other similarly situated members would have believed, on the basis of observation of medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.

14. 24-hour access for members and providers to obtain timely authorization for medically necessary 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.

15. Organization shall approve or deny requests for necessary post-stabilization medical care within one half hour (30 minutes) of the request for Commercial members and 1 hour of request for Medicare members. If the organization does not respond within this timeframe care will be deemed authorized.

16. If the organization and the provider disagree regarding the need for necessary medical care, following stabilization of the enrollee, the organization shall assume responsibility for the care of the patient either by having medical personnel contracting with the organization personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient.

17. An emergency screening fee (Medical Screening Exam) is paid for all ER claims where clinical data supporting a higher level of pay is not available.

18. Non-contracted providers are paid for the treatment of emergency medical condition including medically necessary services rendered to an enrollee until the enrollee's condition has stabilized sufficiently to permit discharge, or to refer and transfer the enrollee to a contracted facility.

19. Enrollees will receive adequate follow-up care when non-emergency care is needed and emergency services are denied in the Emergency Department following a medical screening exam.

SANTÉ PHYSICIANS IPA

Policy/Procedure

EMERGENCY SERVICES SCREENING CRITERIA

Policy: 2.11
Origination Date: 07/1995
Revision Date: 01/2024

The following are guidelines for Utilization Management staff to determine appropriate ER usage and further physician review:

TIME OF DAY: (in conjunction with severity of condition)

- Before 0800, or after 1700 weekdays; or
- Services during standard working hours, if Primary Care Physician referred
- Week-end or holidays

CONDITION:

- Acute (less than 6 hours), sudden (less than 24 hours), severe onset; or
- Condition or symptoms are life threatening or have significant potential chronic disability; i.e., a reasonable person would believe it was life- threatening or disabling; or
- 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.

PRIMARY CARE PHYSICIAN OK:

- With Primary Care Physician or on-call doctor approval.

L&D CHECKS:

- Approved

SYMPTOMS HISTORY AND PHYSICAL FINDINGS

Children less than 15 years old:

- Oral temp greater than 102F (38.8 C) for 36 hours refractory to appropriate treatment (e.g., antipyretics)
- Rectal temp greater than 103 F (39.4 C) for 36 hours
- Unexplained rectal temp greater than 101F (38.6 C) under 2 months old
- Unexplained daily temp greater than 101.6F (38.6C) or rectal temp greater than 102.6F (39.2C) for greater than 2 days.
- Pulse less than 60, or greater than 180 (less than 2 years), greater than 140 (over 2 years old)

Adults:

- Oral temp greater than (103F (39.4C)
- Oral temp greater than 102F (38.9C) with WBC greater than 11,000
- Respiratory rate greater than 24 (acute onset)
- Systolic BP less than 80 or greater than 200
- Diastolic BP greater than 100

All Ages:

- Sudden onset functional impairment such as loss of hearing, speech, sight, sensation or movement of body part; unconsciousness; severe incapacitating pain; disorientation.
- Drop in systolic BP greater than 10 or increased pulse greater than 10 from supine to sitting or standing.
- Vomiting/diarrhea 6 times in 12 hours with any of the following:
  - Na greater than 150 mlEq
  - Hct greater than 50%
  - Hgb greater than 16
  - Urine specific gravity greater than 1.020
  - BUN greater than 20
  - CO2 less than 17-18
  - Ileus on x-ray; x-ray suggesting obstruction
- Chest pain:
  - Intermittent and worsening over time
  - Substernal
  - Not associated with respiration
  - Radiating to arm or neck
- Audible wheezing requiring respiratory therapy treatment and/or epinephrine injection having failed medication/treatment at home (or newly diagnosed, i.e., this first-time encounter for this diagnosis.
- Eye pain or redness in the presence of contact lenses, foreign body or trauma.
- Eye rechecks next day on weekends/holidays when diagnosis is corneal abrasion.
- Laceration of eyelids, vermilion border of the lip or other complex facial lacerations.
- Nose bleeding or any frank bleeding unable to be controlled by conservative measures.
- Sprain/strain in which there is significant swelling or an inability to bear weight.
- Psychiatric loss of control, intoxication, significant confusion or disorientation, or if there is a high probability of a need for security. (Screening examination to determine if a psychiatric emergency exists and to provide treatment to stabilize the member).

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT REFERRAL PROCESS

Policy: 2.12
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:
The Utilization Management Committee oversees the development and implementation of an effective referral process.

Scope:
All referrals for services will be processed according to Santé approved policies and procedures.

Policy:
The Utilization Management staff will follow Santé's approved process for reviewing and authorizing (or denying) requested services. The authorization/referral determination will reflect the appropriate application of Santé's approved practice guidelines.
Santé Physicians IPA providers are not restricted in advocating on behalf of a member or advising a member on medical care. This advocacy may include, but not be limited to, treatment options (without regard to plan coverage), risks, benefits and consequences of treatment or non-treatment, or a member's right to refuse medical treatment and to self-determination in treatment plans.

Procedure:
The Primary Care Physicians act as "managers" and are responsible for ensuring that their patients in need of medical care beyond their scope of practice are referred to appropriate specialist providers. Referral forms are to be used when directing patients to contracted providers for services. (See Contracting and Participating Providers for plan physician names).

GLOBAL CARE REFERRALS

A Primary Care Physician may refer to a specialist for "global" care, effective for six (6) months care (or as specified below) without limitation on number of visits allowed for ONLY the following types of care:

1. "Total OB Care", effective from the date of referral to the six-weeks post partum check.
2. "Global Oncology", to a hematology/oncologist ONLY for ongoing chemotherapy for malignancy.
3. "Radiation Oncology", to a radiation oncologist for ongoing radiation treatment.

4 “Global Allergy”, to an allergist for ongoing allergy treatment.

In this case, the number of visits on the referral is left blank. If the Primary Care Physician wishes the number of visits to be limited, then the referral is completed as usual. The referral process is followed per protocol.

SELF REFERRALS /DIRECT ACCESS

A female member can obtain OB/GYN services without first contacting her PCP. If the member is pregnant, or has a gynecological complaint, she may go directly to an OB/GYN specialist who provides such services in her IPA. If such services are not available in the IPA, she may go to one of the IPA’s referral physicians.

Other direct access/self-referral specialties are defined by individual Health Plan Medical Policies. (Refer to Santé Physicians Administrative Manual, Section: UM, Self referrals.)

STANDING REFERRALS

A member, who requires 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 health care [28 CCR 1300.74.15(f); CA Health & Safety Code 1374.15 (a)(b)] 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 specialized knowledge of HIV medicine, the Provider Group will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria. [CCR 1300.74(f); CA Health & Safety Code 1374.16] Determinations for such requests must be made within 2 business days of the date of receipt of all medically necessary information.

The PCP, specialist or PMG Medical Director determines individually or by consensus that continuing care from a specialist is appropriate care. Referrals are made based upon a designated treatment plan. After receiving standing referral approval, the specialist is authorized to provide healthcare services that are within the specialists area of expertise and training to the member in the same manner as the PCP. Decisions will be made within the timeframes appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed 3 business days of the date that all necessary information is received. The referral for care is to be made within 4 working day of the date of the proposed treatment plan.

The PCP must refer to an Out-of-Network specialist if one is not available within the PMG. Members with standing referrals will be considered candidates for Disease State Case Management and appropriate referrals will be made.

A ‘**standing referral’** must be processed whereby a member is referred by a PCP to a specialist for more than one visit without the PCP having to provide a specific referral for

each visit. If appropriate, a treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized and require that the specialist provide the PCP with regular reports on the health care provided to the member. The referral process is followed per protocol. The approval may include the number of visits, time period for which approval will be made, extension request process, and the reporting required from the SCP to the PCP and/or the IPA Medical Director.

Decisions and determinations regarding authorizing 'standing referrals' will be made in accordance with Standard UM timeframes.

SECOND OPINIONS

Requests by members for 'second opinions' will be processed and provided by a qualified PCP or specialist under certain conditions. These conditions may include:

- The member questions the reasonableness or necessity of a recommended surgical procedure.
- 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
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting tests results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment
- The member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- The authorization process must take into account the member's ability to travel to the practitioner rendering the second opinion.
- Member is responsible only for the costs of applicable co-pays in accordance with his/her plan.
- The delegate may limit the member to one second medical/surgical opinion per medical treatment or surgical procedure, unless additional medical opinions are determined to be medically appropriate particularly in circumstances where the original and the 2nd opinion appear to be in conflict.

Authorizations or denials are to be issued in an expeditious manner. Decisions and notifications will be made and a second opinion provided within the time frames appropriate to the type of request (i.e., urgent, non-urgent, concurrent, retrospective). If a member's condition is such that the condition is an imminent or serious threat to his/her health, including but not limited to, the potential loss of life, limb or other major bodily function the authorization is to be rendered within 72 hours of receipt.

If the second opinion request is about the care the member is receiving from their PCP, an appropriately qualified health care professional, and/or other licensed health care

providers of the member's choice, should give the second opinion. The provider supplying the second opinion must be acting within the scope of practice and possess clinical background and expertise related to the member's illness or condition. The provider should be in the same IPA as the member's PCP.

If the member's request is about the care the member is receiving from a Specialist, an appropriately qualified health care professional, and/or other licensed health care providers of the member's choice, should give the second opinion. The provider supplying the second opinion must be acting within the scope of practice and possess clinical background and expertise related to the member's illness or condition. The provider can be from any participating IPA within the Health Plans network. If the provider is not within the member's IPA, the Health Plan will incur the cost or negotiate the fee arrangement.

If there is no participating Health Plan provider/practitioner within the Provider Group's network or if the member or member's physician requests a second medical opinion outside of the Provider Group's network, they must be instructed to call the Health Plan's Customer Service number on the back of the member's ID card.

The second opinion provider is to provide a copy of the consultation report, recommended tests, and procedures to the initial provider and to the member.

Applicable to organization with Medicare contract: Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient, and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.

SPECIALIST TERMINATION / MEMBER NOTIFICATION / CONTINUITY OF CARE

- Specialist's who intend to terminate their contract with Santé Physicians are required to provide 60 days notification. Notification of the specialist's termination is sent to all Primary Care Physicians. It is the responsibility of the PCP to redirect (refer) the member to an in-plan specialist. The PCP is provided with a list of alternative specialists to whom he or she may refer their members.
- If a member requires ongoing care from a specialist that has terminated their contract, the PCP submits a request for authorization for the member to see the now out-of – plan specialist. The request is subject to medical review.

- Continuity of care is assured for at least 30 days following the actual termination date of the specialist's contract for members for whom it is deemed medically necessary.
- Santé Physician will provide to the Health Plan, upon request, the report of the members and PCP assignment that is provided to the PCP's.
- If the member has been assigned another provider and the terminated provider subsequently agrees to not terminate their contractual relationship. The provider group shall send a letter to the member offering the member the option to return to that provider. (Also see Policy 2:03)

REFERRAL PROCESS

1. The member/client is seen by the Primary Care Physician.
2. The Primary Care Physician generates a written referral and forwards to Santé via fax/mail.
   a. Date received is stamped on referral upon receipt.
   b. Information is verified as to eligibility of the member. Referral is given to customer services if eligibility is not in system. Eligibility is then verified by customer service and returned to UM.
   c. When the referral is received requesting contracted specialists, the referral is data entered for claim payment.
   d. If a member is ineligible or service is not a plan benefit, the Primary Care Physician will be notified and the referral is denied. The Primary Care Physician is notified in writing.
   e. In cases where a member's benefits are exhausted but the member still needs care, Santé assists the member, if necessary, in obtaining other care. This may include:
      - Referring the member to Case Management to assist transition to new provider
      - Obtaining continued care through other sources, e.g. community resources
      - Ancillary Provider Grids are maintained in Administrative Manual and distributed to Santé Community Physician's providers and UM staff.
   f. Verification of contracted specialist provider. If non-contracted, the referral is pended and Primary Care Physician notified that prior authorization is needed.
   g. If PCP office erroneously submits a referral request for a non-contracted specialist, the request is pended and the Primary Care Physician is notified that a prior authorization is needed.
   h. If unauthorized referral to a non-contracted specialist has been completed, the Primary Care Physician is notified and the Primary Care Physician is responsible for any fees generated by the service.
   i. If the service has not been provided by the specialist physician the referral is denied and the Primary Care Physician is instructed to request prior authorization with supporting documentation.
   j. Retro referrals are not accepted.

3. Processing of the referral is completed in a timely manner 3 to 5 working days after receipt at Santé and/or specialty providers.
4. Referral processing does not interfere with or cause delay in service or preclude delivery of services.

SEE ATTACHMENT C: REFERRAL FORM

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT AUTHORIZATION PROCESS

Policy: 2.13
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The Utilization Management Committee oversees the development and implementation of an effective authorization process. This process involves the Utilization Management program methods for reviewing and authorizing (modifying or denying) requested healthcare services. Santé follows ICE TAT Standards for Commercial, Medicare, and Medi-CAL lines of business.

Scope:

All authorizations for services will be processed according to Santé approved policies and procedures.

Policy:

The Utilization Management staff will follow Santé's approved process for reviewing and authorizing (modifying or denying) requested services from contracted and non-contracted providers. The authorization determination will reflect the appropriate application of Santé's approved practice guidelines. Santé Physicians IPA providers are not restricted in advocating on behalf of a member or advising a member on medical care. This advocacy may include, but not be limited to, treatment options (without regard to plan coverage), risks, benefits and consequences of treatment or non-treatment, or a member's right to refuse medical treatment and to self-determination in treatment plans. A representative may facilitate care or treatment decisions for a Medicare Advantage member who is incapable of doing so because of physical or mental limitations

Procedure:

The Primary Care Physician or the specialist (after the appropriate referral) is responsible for obtaining the authorizations necessary to initiate the appropriate medical services. The Santé Utilization Management committee will determine which services require prior authorization.

The Primary Care Physicians act as "managers" and are responsible for ensuring that their patients in need of medical care beyond their scope of practice are referred to

appropriate specialist providers. Referral forms are to be used when directing patients to contracted providers for services. (See Contracting and Participating Providers for plan physician names).

AUTHORIZATION PROCESS

1. PCP/Specialist physicians send requests for authorizations to the Santé Utilization Management Dept. by provider portal, mail, fax or telephone. Portal submissions will be identified by created name not with Sante UM staff. Mail/fax submissions will be identified by upload document with the notes section. Verbal submissions will be identified with the review type comments.

2. The Santé staff date stamps the request when it is received. (Intake Coordinator)

3. Member eligibility and benefits are checked. (Authorization Coordinator)
    a. If a member is ineligible or service is not a plan benefit, the PCP/Specialist will be notified and the authorization is denied. The final notification is written.
    b. If authorization information is incomplete and additional information is required to process, the PCP/Specialist is notified by fax and a telephone follow-up if necessary.

4. Emergent/Urgent authorizations are processed immediately. (Authorization Coordinator UR/R.N., IPA Medical Director) All authorization requests are reviewed upon receipt for diagnosis and requested services to ensure appropriate processing of requests not identified by the requesting MD as 'urgent'

5. Services requiring prior authorization are listed on the forms available to the PCP/Specialist. All other services, if rendered at contracted facilities and/or performed by a contracted physician, do not require prior authorization. Administrative manuals are distributed to all PCP/Specialist offices (contractual grids are found within the manual.) Being certified as a Medicare approved facility is required for performing the following procedures: carotid artery stenting, VAD (Ventricular Assist Device) destination therapy, certain oncologic PET scans in Medicare-specified studies, and lung volume reduction surgery. When authorizing for Medicare Specific Procedures, Authorization Coordinators must refer to the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html to ensure the facility is Medicare-certified to perform the specified procedure.

6. All non-contracted facilities/physicians services require prior authorization.

7. The request is checked for complete information such as:
    a. Member name
    b. Member health plan
    c. Other insurance

d. Member ID Number
e. Requesting provider
f. Referral provider
g. Services that are required as a result of an accident are specified as such and the location of the accident is work, home, auto and/or other.
h. Diagnosis (ICD-10)
i. Documented co-morbidities
j. Clinical history/findings which justify the requested procedure.
k. Clinical conditions that require individualization of criteria
l. Attempted treatment, other consults
m. Medications
n. Requested care, procedure, or test (CPT 4 code)
o. Location or facility
p. Description of service (inpatient, outpatient, office)
q. Estimated length of stay (inpatient requests)

8. If information is incomplete, the request is pended and the necessary data is requested. Pended requests are processed according to time frames outlined in the ICE UM Timeliness Standards. (See Authorization Time Frames at the end of this section). Sante may not deny a nonurgent, urgent preservice or urgent concurrent request that requires medical necessity review for failure to complete prior authorization form.

9. The member's file information is then accessed if it is available.

10. Uncoded services are coded appropriately.

11. The request is submitted to the appropriate personnel who will be responsible for completing the authorization process.

12. Approved practice guidelines are applied and an authorization determination is made by the appropriate personnel. (Utilization Management Coordinators (Auto Auths)/Utilization Management Case Managers (LVN, RN, NP)/Medical Director (MD). Approved criteria is applied for Outpatient and Inpatient determination is made on a case by case basis and follow the below hierarchy:

Commercial HMO Members
Santé Physicians uses the following hierarchy when making Commercial HMO coverage determinations:

1. Eligibility and benefits (Evidence of Coverage)
2. State-specific and Federal guidelines or mandates
3. Health Plan Guidelines and Benefit Interpretation Policies
4. WPATH Standards of Care for the Health of Transgender and Gender Diverse People
5. InterQual, Adult and Pediatric

6. Apollo Managed Care Guidelines
7. Carelon Clinical Appropriateness Guidelines for Diagnostic imaging and Sleep Disorders
8. National Comprehensive Cancer Network
9. Medical Group/IPA Policy

Medicare HMO Members
Santé Physicians uses the following hierarchy when making Medicare HMO coverage determinations:

1. Plan Eligibility and Coverage (benefit plan package or EOC)
2. CMS Criteria
    a. National Coverage Determination (NCD)
    b. Local Coverage Determination (LCD)
    c. Local Coverage Medical Policy Article (LCA)
    d. Medicare Benefit Policy Manual (MBPM)
3. Health Plan Criteria
4. InterQual, Adult and Pediatric
5. Carelon Clinical Appropriateness Guidelines for Diagnostic imaging and Sleep Disorders
6. National Comprehensive Cancer Network
7. Medical Group/IPA Policy

Medi-CAL Members

Santé Physicians uses the following hierarchy when making Medi-CAL coverage determinations:

1. Plan Eligibility and Coverage (benefit plan package or EOC)
2. Medi-CAL Criteria
3. Health Plan Criteria
4. InterQual, Adult and Pediatric
5. Carelon Clinical Appropriateness Guidelines for Diagnostic imaging and Sleep Disorders
6. National Comprehensive Cancer Network
7. Medical Group/IPA Policy

The assessment process includes an evaluation of member-related clinical, psychosocial, and socio-economic factors such as:

- Age
- Co-Morbidities
- Complications
- Home Environment
- Progress of Treatment

13. To make appropriate Utilization decisions, Santé personnel may consider the characteristics of the local delivery system. These may include, but are not limited to:
    - Availability of SNF, sub-acute or home care services
    - Coverage of benefits for SNF, sub-acute, or home care
    - Ability of local hospitals to provide recommended services within the length of stay.
    - Preferred providers
    - Auto Authorization (administrative authorization) process is completed by non-clinical staff and adhere to the Auto Auth list as determined by the Medical Director. *See Auto Auth list.*

14. All non-plan authorizations are referred to the Medical Director/UM Committee.

15. Case Management and concurrent review cases are submitted to the appropriate staff for follow-up.

16. Complex cases are referred to the Medical Director/Utilization Management Committee. Board certified physicians from appropriate specialty areas also assist in making determinations of medical appropriateness. (See attachment: Specialty Advisors)

17. Only licensed physicians make determinations for the modification or denial of requests based upon medical necessity.

18. All authorization requests are followed by notification to the providers of the determination and written notification to the member. The withdrawn or cancellation process must ensure appropriate care is not withheld or delayed for any reason. The written description includes the following:
    - *Examples of a withdrawn or cancelled referral request may include:*
        - *Expired referrals that were previously authorized and unused*
        - *Member not eligible with the Provider Organization*
        - *Added or changed diagnosis and/or procedure codes*
        - *Duplicate requests*
        - *Service is part of the global period*
    - Process, including reasons, for cancelling referral requests that are pending a decision to approve or deny [NCQA UM 4.F.3; 28 CCR 1300.70(b)(1)(D)]
        - Upon the determination of a duplicate, UM staff will notify the requestor
        - Upon provider notification to withdraw chart is updated and noted

- Cancellation process used to cancel utilization requests shall not interrupt or delay patient care or result in underutilization.

19. Approved requests will include an authorization number for the specific services authorized for a minimum of 90 days and include a statement for the provider of service, *within 2 days before the actual date of service, provider must confirm that the member's health plan coverage is still in effect.*

20. Approval letters will be sent to members (in member's preferred language if provided by health plan eligibility files and language template) across all lines of business and health plans to ensure timely notification of authorized services to comply with ICE TAT Standards. *(see ICE TAT standards for Commercial, CMS, and Medcaid).*

21. Initial Provider Notification Timeframe. All prospective review and continued stay review determinations regarding care, which is not underway, must be communicated to the requesting health care provider within twenty four (24) hours of the determination. Voicemails are ~~NOT~~ an acceptable form of oral notification

22. Modifications or Denials for requested services will include a letter to the provider and the member explaining the reason for the modification or denial, suggesting an alternative treatment plan, and informing them of Santé's and the member's health plan appeal process. Notification to the member includes the information that criteria used in the determination are available to the member and instructions on how to obtain the criteria.

    - Medi-CAL Threshold Languages and Alternate Format for Notice of Action (NOA) includes:
        - Verify the enrollee's preferred language prior to issuing the NOA in the appropriate language
        - Verify if enrollee requested alternate format prior to issuing the NOA in appropriate alternate format

23. Authorization application of the criteria.

24. Authorizations, modifications, and denials will disclose upon request utilization management policies, procedure, and criteria used to authorize, modify or deny healthcare services to the public.

25. Authorization disclosure of criteria will be accompanied by the following notification:
"The materials provided to you are guidelines used to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care

and treatment may vary depending on individual needs and the benefits covered under your contract.

26. If UM receives Humana Part D request via fax or other electronic methods, the request should be faxed to Humana's HCPR department at 1-877-486-2621. If UM receives the Part D request verbally over the phone, Sante will instruct the member or prescriber to contact Humana's HCPR department directly at 1-800-555-2546. Sante UM will not accept the request from the physician/prescriber and then forward it to Humana for processing. To be compliant with Section 40.6 of Part C and D Enrollee Grievances Organization Coverage Determination and Appeals Guidance, Humana is unable to accept a verbal request from your organization unless Sante UM is acting in the role as the member's physician/prescriber.

OUT OF NETWORK REFERRALS:

In order to obtain the highest benefit, members must see providers that are within their provider network. Examples of out of network referrals:

- Service or Provider is not available in plan
- Geo-Access – in-plan provider is not available within 30 miles or 30 minutes of member's primary address or workplace
- Participating provider or specialist unable to perform the service
- Member is unable to see in plan provider timely
- Participating provider is not taking new patients

Out of network referrals require prior authorization to determine medical necessity and availability. For Geo-Access, staff will identify and document request the time/distance of member's primary address or workplace to the in-plan provider. Prior authorization for out-of-network requests are reviewed by the Medical Director. If approved, Santé will generally pay for services performed by a non-participating provider with an approved prior authorization as if the provider were participating.

Cultural Considerations

Enrollees 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, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Access and cultural considerations 42CFR438.206 (c)(2). Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and

diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

AUTHORIZATION TIME FRAMES:

Santé will meet all regulatory and contracted health plan mandates for the amount of time allowed to process the authorization request. Santé will make utilization decisions in a timely manner and accommodate the urgency of individual situations. The authorization process will not unnecessarily interfere with or cause the delay of the delivery of services. Weekly and bi-weekly reports track **all** categories of authorization requests whether authorized, pended, modified, or denied.

OUTREACH PROCESS

Prior to Initial Outreach

- Determine if an expedited or standard decision is needed
- Determine the type or level of service being requested
- Determine if any information is missing (needed for approval)

Initial Outreach Attempt

- Make initial outreach attempt, recommended within a few hours of receiving the request.
- Notify provider what information is missing; be specific about what is needed to approve coverage.
- Document how outreach was conducted (e.g., phone, fax) and what was requested.
- Document the date and time of all outreach attempts and whether outreach was successful (all missing information requested is obtained).

Make at Least Two Additional Attempts

- Use methods of outreach different from your initial outreach.
- When feasible, make outreach attempts only during business hours.
- If not within business hours, follow the after-hours instructions, if any, on the provider's voicemail or answering service.
- Leave at least a few hours between attempts for the provider to respond.
- Be specific. Notify provider what information, if any, is missing.
- Clearly document all outreach attempts; note method, date and time.
- Leave at least a few hours from your final outreach attempt prior to issuing a decision.

PROCESSES TO PEND REQUESTS:

Santé Physicians UM Department has a process to pend requests or extend decision times. There will be notification to the practitioner and member when there is a delay in a decision.

Reasons for pended requests:

1) This process includes requests for specialty services, cost control purposes, out-of-network not otherwise exempt from prior authorization.
2) Information was requested but not received.
3) Consultation by an expert reviewer is required
4) Additional examinations, tests, or specific information needed
5) If delegate cannot make a determination for prospective or continued stay reviews within the required time frames, due to not receiving all of the requested necessary information, delegate must immediately notify the health care provider and the member in writing.

Reasons for not pending requests:

1) Senior requests may not be pended if the provider is contracted with Santé.
2) If Santé needs additional information, we must call and/or fax the provider to obtain additional information. Three attempts will be made to obtain additional information, with at least one attempt via call and fax.
3) Benefit or contractual clarifications are not reasons to pend a request.

Member and practitioner are notified within 5 business days of receipt of request and provide at least 45 calendar days for submission of requested information.

The pend letter must include:

1) A specific description of all information required,
2) Type of expert reviewer required, if applicable
3) Time frame for submitting the information
4) Expected date of decision
5) Direct phone numbers for Sante□ Community Physicians and Sante□ Health Systems.

Decisions and notifications must be made within the time frames appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed 3 working dates of the date that all necessary information is received.

For urgent requests decision must be made ***within 72 hours of receipt of the request***. If additional clinical information is required, we will notify member and practitioner within 24 hours of receipt of request and provide 48 hours for submission of requested information.

If a consultation is required by an expert reviewer on an urgent request and 72 hour timeframe cannot be met, there will be notification to the practitioner and member of the type of expert reviewer used and anticipated date on which a decision will be rendered. There will be no more than 15 calendar days from the date of the delay to notification to the practitioner and member of the decision.

EXPEDITED INITIAL ORGANIZATION DETERMINATION:

MEDICARE EXPEDITED INITIAL ORGANIZATION DETERMINATION DECISION:

- If a decision is made to deny expediting the request, Santé UM must process the request through their standard authorization procedure. The 14 calendar day period begins with the day the request was received determination.
- If a decision is made to expedite, Santé UM must make the determination whether adverse or favorable, as expeditiously as the member's health condition requires, no later than 72 hours after receipt of the request.

MEDICARE EXPEDITED INITIAL ORGANIZATION DETERMINATION NOTIFICATION:

- Practitioner and member are given verbal, electronic or written notification of approval decisions within 72 hours after request.
- If only written notice of approval decision is given, it must be received by member and practitioner within 72 hours after request.
- Practitioner and member are sent written notification of denial decisions within 72 hours after request. The notice must be received within 72 hours of receipt of request.
- When verbal notice of denial decision 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 verbal notice.
- If the determination is adverse (e.g., service denial), Santé UM must issue an appropriate notice of denial of medical services to the member.
- If Santé UM fails to provide the member with timely notice of a determination, this failure itself constitutes an adverse organization determination and may be appealed.

MEDICARE EXPEDITED INITIAL ORGANIZATION DETERMINATION EXTENSION:

- The 72-hour deadline may be extended up to 14 calendar days only if member requests or Santé UM justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (e.g., the receipt of additional medical evidence from non-contracted practitioners may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted practitioners.
- Sante UM does not utilize the extension process for any Medicare health plan.
- Practitioner and member are given written notification of the decision to extend within 72 hours of receipt of request.

- Member will be notified in writing of the reasons for the delay and informed of the right to file an expedited grievance if he/she disagrees with Santé UM decision to grant an extension.
- Decision is made no later than upon expiration of the extension.
- Practitioner and member are given verbal, electronic or written notification of approval decisions no later than upon expiration of the extension.
- If only written notice of approval decision is given, it must be received by member and practitioner no later than upon expiration of the extension.
- Practitioner and member are sent written notification of denial decisions no later than upon expiration the extension. The notice must be received no later than upon expiration of the extension (no longer than 14 calendar days after receipt of request)
- When verbal notice of denial decision is given, it must occur no later than upon expiration of extension and must be followed by written notice within notice within 3 calendar days of the verbal notice.
- Santé UM will track all expedited initial organization determination requests with the following elements:
  - Member name/identification
  - Date and time of receipt of the request
  - Date and time of medical record requests
  - Date and time all information received
  - Extension filed, if applicable
  - Date and time of decision
  - Date and time of verbal notification
  - Date and time of written notification

MAIL POLICY FOR UM DETERMINATIONS

All health plans and all lines of business will follow the same mail policy for UM determinations.

1. Approval/favorable determination letters for Commercial, Medicare, and Medicaid
   a. Urgent and non-urgent requests
      - Approval letters will be mailed out the same business day of effectuated date to include overnight deliveries. To comply with ICE TAT Standards for timely notification, letters mailed out each day will be recorded on the UM mailed out log to include all lines of businesses.

2. Denial/adverse/modified letters for Commercial, Medicare, and Medicaid
   a. Urgent and non-urgent requests
      - Denial letters will be mailed out the effectuated date to include overnight deliveries. To comply with ICE TAT Standards for

timely notification, letters mailed out each day will be recorded on the UM mailed out log to include all lines of businesses.

3. All letters will use the *Important Plan Information* envelopes

4. All UM member letters will have a status within the dispatch mode of (print now or batch print) to be identified with a date and time as being printed.

    1. All outgoing mail including correspondence and member notification is picked up in the mailroom once a day in the afternoon at 3:30pm Monday through Friday. All recorded mail time will be 15:30:00 each day, all letters printed by 15:00:00 will go out the same day. Each Friday or day before holidays, member letters will be mailed by UM Staff up until 17:00:00 and taken to the Post Office. All recorded mail time will be 17:30:00. Weekend/holiday urgent/non-urgent Part B Drug requests will be monitored by designated UM staff. Urgent/non-urgent Part B Drug requests will be identified within Quick Cap system. Requests received over weekends/holidays will be processed. Oral notification to member will be completed to meet member notification and written notification will be completed the next business day. If oral notification is not completed (due to no phone number, disconnected, or incorrect phone number) written notification will be completed via Fed-Ex Same Day or Overnight delivery to meet timeliness.

5. Return mail (undeliverable mail), any returned mail by the Post Office as undeliverable is to be researched using the following methods:

    a. If the mail is returned with a sticker indicating the current address we will update our system with it and resend the mail.
    b. The member's file (notes) from provider are reviewed to see if a current address was provided.
    c. UM staff will review EPIC to see if member's current address is valid
    d. If nothing is found, UM staff will call PCP office to obtain the most current address they have on file.

COMMUNICATION SERVICES:

Utilization management department maintains telephone access for providers to request authorization for health care services.

a) The UM Staff is available 8 hours a day during normal business days for inbound calls, regarding UM issues.

b) UM Department has the ability to receive inbound communications after normal business hours. There is a phone line that records messages. These are promptly reviewed at the start of new business day. Director/Manager of UM Department is available by phone 24 hrs/day.

c) Staff always identifies themselves by name, title, and by IPA name when initiating or returning calls, regarding UM issues.

d) Inbound and outbound communications may include directly speaking with Practitioner and members, fax, electronic, or telephone communications during normal business hours, unless otherwise agreed upon.

e) A toll-free number or collect calls may be used for practitioners or members to reach the staff for triaging or to discuss specific UM cases or issues.

f) Members may have direct access to UM staff to discuss specific UM decisions and process to include TDD/TTY services for the deaf and Language assistance for Limited English Proficient (LEP) HMO members.

SANTÉ PHYSICIANS IPA

Policy/Procedure

PRESCRIPTION DRUG PRIOR AUTHORIZATION PROCESS

Policy: 2.13a
Origination Date: 01/2017
Last Review Date: 01/2024

Purpose:
To describe the process followed by Utilization Management (UM) to meet state pharmacy prior-authorization regulations SB-866 and SB-282.

Definition:

- *SB-866*: This bill would require the Department of Managed Health Care (DMHC) to develop a prior authorization form for use by every health care service plan and health insurer that provides prescription drug benefits, except as specified.
- *SB-282*: This bill would authorize the prescribing provider to additionally use an electronic process developed specifically for transmitting prior authorization information that meets the National Council for Prescription Drug Programs' SCRIPT standard for electronic prior authorization transactions.
- *Prescription Drug Prior Authorization Request Form*: A uniform prior authorization form developed by DMHC that would require prescribing providers to use, and Sante Community Physicians to accept, only those forms or electronic process.

Policy:
Santé Physicians has established a process in the review and processing of prior authorization request for prescription drugs. The ICE UM Timeliness standards will be followed to comply with the mandated turn-around time.

Procedure:

A. Pharmacy Prior Authorization:
   1. Requests may be submitted using the Prescription Drug Prior Authorization Request Form or the Sante Prior Authorization form. The provider cannot be required to submit other forms, but may elect to include additional attachments with the form.

   2. Santé Physicians will only request that minimum amount of information necessary to approve/deny request. The provider will be required to include only the necessary information to complete the request form.

3. Determinations will be made within the required timeframe according to ICE UM Timeliness standards.

4. Notification will indicate:
   a) The request is approved;
   b) The request is denied as not medically necessary;
   c) The request is denied as not a covered benefit;
   d) The request is denied as missing clinical information. Requests may not be pended for additional information, but must be denied as needing additional information;
   e) The member is not eligible; or

5. Denial written notification will include an accurate and clear explanation of the reason for denial.

B. Prescription Drugs Timeliness Standards:
   1. Santé Physicians will make a determination and notify the prescribing provider within the required timeframe (refer to ICE UM Timeliness standards).

      a) Urgent – within 24 hours of receipt of request; and

      b) Non-urgent – within 72 hours of receipt of request.

   2. Santé Physicians will make every effort to comply with the mandatory timeframe as required by law, and make sure there are no systemic issue with the internal process that prevent these types of requests from receiving timely review and determination.

   3. Weekend/holiday urgent/non-urgent Part B Drug requests will be monitored by designated UM staff. Urgent/non-urgent Part B Drug requests will be identified within Quick Cap system. Requests received over weekends/holidays will be processed. Oral notification to member will be completed to meet member notification and written notification will be completed the next business day. If oral notification is not completed (due to no phone number, disconnected, or incorrect phone number) written notification will be completed via Fed-Ex Same Day or Overnight delivery to meet timeliness.

   4. If a decision is not made within the required timeframe, the request it is deemed approved. [CA Health and Safety Code 1367.241(b)]

Medicare Part B Drug Adjudication Timeframes

New processing timeframes for Part B drug (including step therapy drugs) initial determination requests will be:

- Expedited Organization Determination: **24 hours** from the date and time of request. Extensions cannot be granted.
- Standard/Routine Organization Determination: **72 hours** from the date and time of request. Extensions cannot be granted.

Step therapy means a utilization management policy for coverage of drugs that begins medication for a medical condition with the most preferred or cost-effective drug therapy and progresses to other drug therapies if medically necessary.

SANTÉ PHYSICIANS IPA

Policy/Procedure

PRE - SERVICE REVIEW

Policy: 2.14
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The Utilization Management Committee oversees the prospective review of requests for service authorization in order to monitor continuity and coordination of care, and to assist in the utilization of appropriate services.

Policy:

1. Prospective review of referral/authorization requests will include specialty consultations, selected medical treatments and services, hospital admissions, emergency services, rehabilitative and ancillary services, home care and hospice services, and out of plan referrals.

2. The Utilization Management staff will identify catastrophic and chronic services for case management and focused Utilization Management committee review.

3. Approved practice guidelines will be appropriately applied to all requests for service.

4. All determinations will be documented and available to Santé Physicians contracted providers.

5. Prospective review of authorization requests will be conducted according to the Santé Physicians approved policy and procedure for the referral/authorization process.

SANTÉ PHYSICIANS IPA

Policy/Procedure

CONCURRENT REVIEW

Policy: 2.15
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The care of hospitalized members is reviewed on a concurrent basis in order to determine that service delivery and the level of care is appropriate. The member's progress also is evaluated in order to plan for a timely discharge from the hospital. Santé follows ICE TAT Standards for Commercial, Medicare, and Medi-CAL lines of business.

Policy:

1. Concurrent review will be conducted on all hospitalized Santé members by licensed UM/CMSS staff. Such review will include physician communication, telephonic review, on-site and chart review and ongoing communication with other healthcare professionals who are involved in the member's care.

2. Santé approved guidelines for justifying medically appropriate services and length of stay will be applied in a consistent manner, utilizing, health plan standards and Interqual criteria.

3. The discharge planning process will be in place at the time of the member's admission and will be an integral part of the management of the member's care.

4. The Utilization Management Committee will do focused review of complex cases.

5. Chronic or catastrophic cases may be referred for Community Case Management follow up and will be reviewed by the Utilization Management Committee. The appropriate health plan will be notified of all chronic or catastrophic cases.

Procedure:

The following is the concurrent review process:

1. The Admitting Department of the affiliated hospital promptly notifies the UM Dept./UM Nurse of a Santé member's admission to the hospital (see Hospital Admissions Tracking Policy and Procedure).

2. The UM nurse will review inpatient admissions in accordance with Health Plan requirements.

3. Medical necessity as well as the appropriateness of the admission will be assessed, and approved Santé guidelines will be applied. An appropriate admission at the proper level of care may be authorized. Determination of medical necessity as well as the appropriateness of the admission/service will be completed within one working day of obtaining all necessary information.

4. Continued stay review determinations regarding care that is underway must be communicated to the attending physician within twenty four (24) hours of the determination. All adverse determinations must be communicated to the covered person (regardless of whether the covered person has financial responsibility) in writing within two (2) business days of the determination. Continued stay review care, must not be discontinued until the covered persons treating health care provider has been notified of our determination and a care plan has been agreed upon by the attending physician that is appropriate for the medical needs of that covered person.

5. Complex and controversial cases, which require the advice of the Medical Director, are referred to that physician immediately for authorization or denial. These cases also are presented to the UM Committee on a retrospective basis.

6. If a questionable or seemingly inappropriate admission takes place, the Medical Director will discuss the case with the attending physician. If the attending physician agrees with the Medical Director or designee that hospitalization is not necessary, he/she will arrange for the member to be discharged.

   If the attending physician does not agree with the Medical Director, the case will be reviewed by the Utilization Management Committee or a delegated review Subcommittee.

7. Appropriate services and care shall not be discontinued until the members treating/attending provider has been notified of the PMG's decision, and a

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

8. The admission then will be authorized or the member will be discharged by the attending physician. If the member is discharged, the denial process will be implemented (see Service Denial and Appeal Process Policy and Procedure), and denial letters will be issued the same day.

9. All actions and decisions will be documented.

10. The concurrent review and discharge planning processes will be initiated immediately upon notification of the member's admission per policy. Summaries of the reviews may be reported to the member's health plan medical management staff as per contract agreement, until the member is discharged from the hospital.

11. A continued stay review for each member's hospitalization will be based on the application of (Santé) approved severity of illness and intensity of service criteria. Additional hospital days are justified and authorized accordingly, and indications for certain services are identified. Similarly, plans for discharge and the restriction of certain services are identified.

12. The discharge planning assessment includes an evaluation of member-related clinical, psychosocial, and socio-economic factors such as:
    - Age
    - Co-Morbidities
    - Complications
    - Home Environment

13. The UM Nurse refers complex or controversial continued stay cases to the Medical Director, and the attending physician is involved to provide clinical information. If continued stay is appropriate, the additional days will be authorized. If the member should be discharged, the attending physician will initiate this action. If there is a difference in opinion between the (Medical Director) and the attending physician, counsel will be sought by the UM Committee or a delegated review Subcommittee. The continued stay then is either authorized or denied. If it is authorized, the appropriate number of days is assigned. If it is denied, the denial and appeals process is initiated (see Service Denial and Appeal Process Policy and Procedure), and denial letters will be sent the same day. For Medicare members, CMS requires the Detailed Notice of Discharge (DND) to contain at least the following information: a) a detailed explanation about why the services are either no longer reasonable/medically necessary or are otherwise no longer covered; and b) a description of the Medicare coverage rules/policies upon which the

action is based. Delegate to ensure members received the DND by noon of the day following notification by the QIO.

14. Focused reviews will be conducted on known problem diagnoses, procedures, or providers who require guidance in managing the utilization of services.

15. Daily concurrent review will include the identification of problem prone, high risk, or high cost cases. The appropriate referrals will be made to case management, and in incidences of high cost/high risk cases, the health plan case management department (corporate) is also notified.

16. Notification to health plan when acute inpatient admits expect or exceed length of stay greater than 7 days; acute rehab or SNF stays greater than 21 days.

17. Identifying organization staff at the facility, in accordance with facility procedures.

18. A process for scheduling the onsite review in advance, unless otherwise agreed upon.

19. A process for ensuring that staff follows facility rules.

SANTÉ PHYSICIANS IPA

Policy/Procedure

RETROSPECTIVE REVIEW

Policy: 2.16
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

When deemed necessary, the Utilization Management Committee conducts retrospective review of cases that were not previously authorized and of claims which require authorization for payment. The retrospective review also includes tracking and trending and analysis of utilization statistics.

Policy:

1. The Utilization Management Committee will retrospectively review and make authorization determinations on all cases that require authorization.

2. All requests for Retrospective review (when deemed appropriate) are to be completed within 30 days of obtaining all the necessary information to enable a determination.

3. Qualified health professionals assess the clinical information used to support UM decisions and appropriately licensed health professionals supervise all review decisions.

4. Relevant clinical information will be obtained and the treating physicians will be consulted as appropriate. Approved practice guidelines/criteria will be applied and all determinations will be documented and available to contracted providers.

5. Only licensed physicians will make determinations for the denial of requests based on medical appropriateness.

6. Utilization statistics will be tracked, trended, and analyzed by the UM Committee and reports will be presented to the Santé Physicians IPA at least on a quarterly basis (see Policy 3.04 Utilization Management Reports).

SANTÉ PHYSICIANS IPA

Policy/Procedure

SERVICE DENIAL

Policy: 2.17
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:
A consistent procedure is followed by the Santé staff to inform providers and members of denied and modified requests for service. The procedure includes notification of the member's Health Plan appeals process and the steps required for its implementation and the member's right to request an independent medical review (commercial & Medi-Cal only).

Scope:
The UM staff will work with other Santé departments such as Quality Improvement, Claims, and Customer Services to ensure that accurate information is given to the members and providers when a denial or modification for service is processed. Only licensed physicians will make determinations for the denial or modification of requests based on medical appropriateness.

Policy:

1. Utilization Management staff will send denial or modification letters to providers and members (for authorization requests for service), after UM designated physicians have determined the requests to be inappropriate. Santé will meet all regulatory and contracted health plan mandates for the format and method of notification.

2. Only California licensed physicians who are competent to evaluate specific clinical issues may deny or modify authorization requests basing their determinations on medical necessity. If necessary, experts in specific fields may provide medical advice. The identity of these experts is available upon request and will be provided to the requesting provider or member.

3. All denial and modification letters will be dated and signed by a Santé Physicians Medical Director.

4. Santé will meet all regulatory and contracted health plan mandates for the timeliness of processing denials and modifications. Santé will accommodate the urgency of individual situations. Denials and modifications will be documented for tracking purposes. (See Policy 2.13, Authorization time Frames)

5. Denial and modification logs will be produced and sent to each health plan weekly.

6. Reopening is an action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

7. All appeals will be handled in an efficient manner according to Santé approved procedure. All 1st level appeals are referred to the Health Plan for determination. (See Policy 2.18 Appeals & Policy 2.19 Expedited Review Process)

Procedure:
The following is the process for the denial, modification, reopening and appeal notification and follow-up procedure:

1. In the event that the Santé Medical Director denies or modifies the requests for services, denial or modification letters are sent to members and providers notifying them of the final determination. Denial rationale by the Medical Director will be documented and included in the file to ensure it matches the denial rationale contained in the denial notice sent to the member. These denial or modification letters are used to communicate to the member and provider that the requests are inappropriate. The reason for the denial or modification is always explained in easily understandable language to the members in the letters. Denial or modification notification is sent to all practitioners participating in the treatment of the member (when identified in the request for authorization of services).

2. The letters are computer-generated, and are sent after the determination has been made. All Commercial, Medicare, and Medi-CAL denial templates will use current approved templates. Specific to Medicare, use of current CMS Integrated Denial Notice/Notice of Denial of Medical Coverage Template. And must be in 12 point font. All Commercial, Medicare, and Medi-CAL denial and modification letters will be saved as PDFs. Letters will be attached to each authorization within the Quick Cap system. All letters will include:
    - The explanation for the denial or modification, a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based
    - Routine Decision Timeframe for Incurable Condition must provide a determination within five (5) business days when issuing an adverse determination for a member that has been diagnosed with an incurable or irreversible condition and that has a high probability of causing death within one year or less.
    - Denial letter contains information for member to obtain a copy of the criteria used to make the adverse decision

- Education regarding the issues involved.
- A specific explanation about what information is needed to approve coverage.
- The specific Title 22 regulation citation
- Denial reasons for Medi-CAL will be written at 6th grade reading level.
- A suggested alternative treatment plan,
- Translation of Medi-CAL or Medicare denial reason in member threshold language will follow each health plan's process through their provided vendor or within the translation function of Quick Cap.
- Notification that information regarding the physician reviewer responsible for the determination and their direct phone contact have been supplied to the requesting provider. For Medicare, peer to peer will occur prior to adverse decisions. If the offer was made by telephone, including voicemails, documentation and denial notification includes name of the individual who notified the treating practitioner or left the voicemail, and the date and time of the notification or voicemail.
- If additional information is received after an adverse decision Sante will handle it as an appeal and forward it to the Health Plan (see 2.18 appeals).
- An explanation regarding the appeals process with the member's health plan.
- A description of the members' rights to request an independent medical review.
- Medi-CAL Notice of Action (NOA) termination letters may be generated and follow the same process as denials and modification letters
- Medi-CAL Threshold Languages and Alternate Format for Notice of Action (NOA) or Integrated Denial Notice (IDN) includes:
    - Verify the enrollee's preferred language prior to issuing the NOA or IDN in the appropriate language
    - Verify if enrollee requested alternate format prior to issuing the NOA or IDN in appropriate alternate format

  (*See health plan denial letter templates*).

3. Requests for service authorization are reviewed to determine medical appropriateness:

4. Requests for authorization of services may be denied or modification for the following reasons.
    a. The provider is not contracted with Santé.
    b. The service is not medically necessary.
    c. The member is not eligible.
    d. The service is not a covered benefit.
    e. The member's benefits for that service have been exhausted.

5. Not a covered benefit denials such as:
    a. Incontinence Supplies
    b. Tub Bench/Transfer bench for tub or toilet without commode opening
    c. Hospital Bed, total electric

   The above will be handled as administrative denials that are not covered by CMS. These administrative denials will be handled by staff and/or clinical staff and bypass the Medical Director.

6. In cases where a member's benefits are exhausted but the member still needs care, Santé assists the member, if necessary, in obtaining other care. This may include:
    - Referring the member to Case Management to assist transition to new provider
    - Obtaining continued care through other sources, e.g. community resources

7. Requests for authorization of services for Medicare/HMO members are denied or modified **in accordance w/Medicare Guidelines and the ICE Medicare Advantage Pre-Service Denial Matrix.**

8. System controls specific to denial notification will follow as; Date of receipt will be noted within the Requested Date Time Field within the Quick Cap system. Date of decision will be noted within the Review Type-Comments field. Date of written member notification (when member letter was generated, when member letter was printed) is noted by the system within the letter generation listing and identified in the Status, Status Date-Time log. All dates and times are auto populated by the Quick Cap System. Notification to provider will be within 24 hours of decision and/or within the stringest time frame to meet TAT standards for all lines of business. Denial notification is limited to Senior UM staff only. Senior UM staff work on denials notification as appropriate. Tracking of all authorizations is available within the authorization with the Audit Trail link. Monthly reports have been set up in reporting system as needed to demonstrate the complete lock down of the system. System tracking report is done for all fields and identifies all changes from requested date/time through the entire life of the authorization. System Security controls in place to protect data from unauthorized modification follows policy (2.24 Modifying Authorizations). Internal audit process is conducted on a quarterly basis during Inter-Rater Reliability of Medical Director decisions.

9. Reopening and revising denied or modified organization determinations may be verbally or in writing initiated by one of the following:
    - Health Plan revises the organization determination or reconsideration
    - Independent Review Entity (IRE) revises the reconsidered determination

- Administrative Law Judge (ALJ) revises the reconsideration per a hearing decision
- Medicare Appeals Council (MAC) revises the hearing or review decision.

10. Reasons for reopening denied or modified organization determinations
    - New and material evidence that was not available or known at the time of the determination or decision, and that may result in a different conclusion
    - Evidence that was considered in making the decision clearly shows that an obvious error was made at the time of the determination or decision.
    - Clerical errors
        (i) When processing a reopen for clerical errors, if the organization disagrees there is a clerical error, they must dismiss the reopening request and advise the party of any appeal rights, provided the time frame to request an appeal on the original denial has not expired.
    - Human and mechanical errors
    - Mathematical or computational mistakes
    - Inaccurate coding and computer errors.

11. Dissatisfaction is not grounds for a reopening, and should not be submitted.
12. Guidelines for requesting a reopening
    - An appeal and a reopening may not occur simultaneously.
    - Request is made in writing
    - Request is clearly stated
    - Request includes the specific reason for requesting the reopening
    - Request is made within the timeframes permitted for reopening

13. Time frames for reopens when requested
    - Within 1 year from the date of the organization determination or reconsideration for any reason
    - Within 4 years from the date of the organization determination or reconsideration for good cause
    - At any time if there exists reliable evidence (e.g., relevant, credible, and material) that the organization determination was procured by fraud or similar fault
    - At any time for the purpose of correcting a clerical error on which the determination was based
    - At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD) appeals process.

SANTE PHYSICIANS IPA

Policy/Procedure

NOTICE OF MEDICARE NON-COVERAGE

Policy: 2.17.5
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

Santé Physicians is responsible for issuing all notices of Non-Coverage of Concurrent Care/Termination of SNF, HHA and CORF Services. A termination of service is the discharge of a member from covered providers/practitioners, or discontinuation of covered providers/practitioners services, when the member has been authorized by the Provider Group to receive an ongoing course of treatment from the provider/practitioner.

Policy

- Santé will audit its UM department for compliance with timeliness of notification and appropriate use of Medicare letter templates and denial reason matrix, and compliance with all standards for processing Medicare UM member standard authorizations and denials.
- Santé will issue the "The "Notice of Medicare Non-Coverage" (NOMNC) when a member is discharged from a Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services or;
- A determination that such services are no longer medically necessary with the respect to the applicability of the fast-track appeals process to situations involving the exhaustion of benefits, termination of services based on the exhaustion of Medicare benefits (100 calendar days), per CMS directive, the Integrated Denial Notice (IDN) should be used to convey this information, rather than the NOMNC. The QIO (Quality Improvement Organization), does not normally conduct appeal reviews related to exhaustion of benefits, therefore, these appeals must be handled by health plan Senior Services.
- Santé will ensure that their individual health plan NOMNC template contains the following:
  - Name, address and phone number of the entity issuing the NOMNC must be at the top of the letter.
  - The date that coverage of services ends
  - The date that the member's financial liability for continued services begins
  - How to contact the QIO
  - Description of the member's right to a fast-track appeal with the QIO
  - The member's right to receive detailed information on why coverage is ending

- Information on the availability of other Health Plan appeal procedures if the member fails to meet the deadline for a fast-track appeal
- The NOMNC must include the following:
  - OMB Control Number is correctly stated in the lower right corner of every page
  - Marketing approval number and Medicare Approval Date are correctly stated in the bottom left corner of every page.
  - Form number and date are stated above the marketing approval number
  - Member name
  - Delivery date
  - Appeal information includes correct Health Plan demographic information
  - Font will be size 12, Times New Roman
  - The envelope must state "Important Plan Information".

- Santé will ensure the issuance of the NOMNC that notifies the member of the termination of services or discharge, no later than 2 calendar days or 2 visits before the proposed end of services.
  - If the member's services are expected to be fewer than 2 calendar days or 2 visits in duration, member must be notified at the time of admission or upon initiation of services.
  - In a non-institutional setting, the notice must be given no later than the next to last time services are furnished.
- The member or the member's representative must sign and date the notice upon delivery to indicate that he or she has received the notice and understands the purpose and contents of the notice.
- Delivery of Notice to Representative – Representative - an individual member has authorized to act on his or her behalf and/or a person who has Durable Power of Attorney for Health Care of the member.
  - Representatives of incompetent members may be notified by telephone if personal delivery is not immediately available. Telephone contact requirements include:
    - Telephone contact with the representative must convey the notice contents.
    - Conversation must be documented in the member's record. The date of the conversation is the date of receipt of the notice.
    - Confirm telephone contact with written notification mailed the same day.
- Written Notice to Representative
  - If telephone contact is not possible, the notice must be sent via certified mail, return receipt requested.
    - The date that someone at the address signs is the date of receipt
    - If the member and/or their representative refuse to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the member and/or the representative refused to sign.

        - Post office returns with no indication of refusal date, the member's liability begins on the second business day after mailing.
- If the member disagrees with the termination of services/discharge, the member must contact the QIO, verbally or in writing, no later than noon of the day before the services are to end.
- The QIO immediately notifies Health Plan Senior Services and provider of the member's request for a fast-track appeal.
- Upon notification by the QIO that a member or representative has requested an appeal, the Provider Group must issue the Detailed Explanation of Non-Coverage (DENC) to both the QIO and member no later than close of business of the day the QIO notifies the HP of the appeal.
- Clinical staff will be available on weekends to issue Detailed Explanation of Non-Coverage (DENC)
- The DENC must include the following:
  - Name, address and phone number of the entity delivering the DENC is at the top of the notice.
  - Member name
  - Date notice was generated
  - Member identification number
  - Type of service being terminated (e.g., SNF, HHA, CORF)
  - Facts used to make the decision
  - Detailed explanation of why current services are no longer covered
  - Specific Medicare coverage rules and policy used to make decision
  - Statement of availability of Policy or Coverage Guidelines
    - "If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: 800-652-2900"
  - OMB Control Number is correctly stated in the lower right corner of every page
  - Marketing approval number and Medicare Approval Date are correctly stated in the bottom left corner of every page
  - Form number and date are stated above the marketing approval number
  - The envelope must state, "Important Plan Information".
- Health Plan Senior Services will obtain records from provider, and send copy of the medical records to the QIO by close of business day of notification. Health Plan Senior Services may request that the records be send directly to the QIO.
- The QIO must make a decision and notify the member and Health Plan Senior Services by close of business the following day. On the next business day, Health Plan Senior Services will notify "Santé of the fast-track appeal request and the QIO's determination.
- If the decision is overturned "Santé must prepare and issue a new NOMNC notice when new discharge orders are written.

Process:

1. Once authorization has been entered into Quick Cap system, NOMNC packet will be created by Authorization Coordinator.
2. NOMNC packet will include:
    a. Fax transmission cover sheet to include;
        i. Company name
        ii. Phone/fax number
        iii. RN contact
        iv. RN phone number
        v. Date
        vi. Number of pages
        vii. Member name
        viii. Health Plan
        ix. Auth number
        x. Admit date
        xi. Directions to send weekly reviews on Monday or Tuesday
        xii. Directions to provide NOMNC at least 48 hours prior to services ending and fax back all pages with member signature
        xiii. NOMNC template for specific health plan with SNF, HHA, CORF contact info within the header, member name, patient number/member ID number
        xiv. Notice of Non-Discrimination
        xv. Multi-Language Interpreter Services
        xvi. Optional Form to Document Alternate Delivery

3. NOMNC log will be updated for all issuance of NOMNCs to SNF, HHA, and CORF facilities.
4. NOMNC log will be monitored on a monthly basis, if NOMNCs are not received a call or fax will be sent to facility/vendor requesting a copy of the signed NOMNC issued to member. Documentation of receipt or non-compliance will be recorded. NOMNC log will be available upon request.
5. Non-compliant providers will be provided to Health Plan Provider Relations contact on a quarterly basis.

SANTÉ PHYSICIANS

Policy/Procedure

APPEALS

Policy: 2.18
Origination Date: 07/1995
Last Review Date: 01/2024

Process:

1. UM Appeals are those received from members or providers with regards to the denial decision of a request for service made by the Medical Director or the Associate Physician Advisor.

2. All first level appeals are reviewed and determination made by the Health Plan.
   - All appeals will be forwarded to the Health Plan within 1 hour.
   - For expedited appeals, record will be sent within 2 hours.
   - For standard appeals, records will be sent within 24 hours.
   - All transplant appeals are referred and handled by the Health Plan.
   - Member calls for appeal – Santé UM Department will direct the member to call member services as listed on the back of the member's cared or warm-transfer the member to that number.

3. IPA/PMG must respond in appropriate time frame, as requested by Health Plan when appeals are processed.

4. Appeals must be made in writing within 180 or 365 days dependent on the Health Plan guidelines of notification of the 1st denial and may or may not include additional information, which the member/provider feels would be helpful.

5. If the member or provider chooses to appeal the denial decision:
   a. The member, provider, or authorized representative may act on behalf of the member and may file an appeal with the Health Plan as directed in the denial letter. Notification to the member about further appeal rights is part of the denial letter and can be found on the second page under "Important Information About Your Appeal Rights".
   b. Member is allowed at least 60 calendar days after notification of the denial for the member to file an appeal.
   c. The Health Plan may contact the IPA to request additional documented information pertinent to the appeal request. Documenting the substance of a pre-service appeal and any actions taken.

d. The Health Plan will gather and research the appropriate documented information pertinent to the appeal. Santé Physicians will support the full investigation of the substance of the appeal, including any aspects of clinical care involved.
e. The Health Plan will provide the member with continued coverage pending the outcome of the appeal process.

6. All appeals will be reviewed and resolved by the Health Plan within 30 calendar days of receipt without exception.

7. Members will have continued coverage for covered services, pending the outcome of an appeal. This applies to covered services only, as plans and insurers cannot reduce or terminate an on-going course of treatment without providing advanced notice and an opportunity for advance review.

8. The Health Plan will notify the member, provider and IPA in writing within 24 hours of the determination. If the decision is overturned, approval letter will be provided to the Health Plan, provider and member.

9. If the Health Plan denies a service or treatment because the plan determines it is not medically necessary, experimental, or investigational the member may request an external review/appeal. Expedited external review can occur concurrently with the internal appeals process for urgent care. Member must contact their Health Plan customer service for contact information.

10. For Medicare appeals:
<u>Expedited</u>
- Medicare expedited appeals will be directed to call the Senior Market, Grievance and Appeal Department.
- For expedited verbal appeals, members will be directed to call the Senior Services Grievance and Appeal Department.
- Expedited written appeals will be faxed immediately.
- For expedited appeals, medical records will be sent within 24 hours or sooner.

<u>Standard</u>
- All standard appeals will be referred to the Senior Services Grievance and Appeal Department.
- All standard appeals will be in writing.
- Standard written appeals will be faxed immediately.
- For standard appeals, medical records will be sent within 7 calendar days.
- All transplant appeals are referred and handled by the Health Plan.

SANTÉ PHYSICIANS

Policy / Procedure

EXPEDITED REVIEW PROCESS

Policy: 2.19
Origination Date: 06/1998
Last Review Date: 01/2024

Purpose:
To establish a consistent and efficient process for the review of Medicare/HMO member authorization requests and appeals. This procedure includes organizational determinations (authorizations and denials) and reconsideration (appeals).

Scope:
Utilization staff will integrate its functions with other departments such as Claims, Appeals, Quality Improvement, Customer Services and the Health Plans to ensure that accurate information is used in the determinations and that reviews are accomplished in the time frames established for the expedite process.

Definition of Expedited Review:
Expedited initial determination and /or expedited appeal is used in situations that are considered "time sensitive". A "time sensitive" situation is defined as a situation where waiting for the standard decision making process could seriously jeopardize a member's life, health or jeopardize the member's ability to regain maximum function. This situation may include but not be limited to severe pain, potential loss of life, limb or major bodily function. Expedited appeals will include all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but who has not been discharged from a facility.

Expedited Review/Appeal Time Frames:
Santé will meet all regulatory and contracted health plan mandates for the amount of time allowed to process the authorization requests and/or appeals. Santé will make utilization decisions in a timely manner and accommodate the urgency of individual situations. The authorization process will not unnecessarily interfere with or cause the delay of the delivery of services. Weekly and bi-weekly reports track **all** categories of authorization requests whether authorized, pended or denied

Expedited Initial Determination

Policy:
A member or their authorized representative (including M.D.) may make requests for standard and expedited determinations (orally or written). Receipts of oral requests are

documented in writing by the plan or provider. The appeal must be reviewed a decision made, and the member and the member's physician notified in an expeditious manner.

An extension may be permitted if it is necessary to obtain additional information and the delay is in the interest of the member or if the member requests the delay. The member will be informed in writing of any delay. The need to obtain medical information from any provider affiliated with Santé, however, is not a reason to extend the time frame. Sante does not utilize the extension process for all Medicare plans.

Change of review priority, after a request is initiated as a standard or expedited review, a provider may contact UM to change the review priority. If the provider indicates that the enrollee's health requires an expedited decision, the plan must begin the applicable expedited review period at the time they receive the physician's request to expedite the decision.
Note: A change of priority does not allow for extra review time. If the remaining standard review period is less than the applicable expedited review period, the original standard deadline still applies

Decision Not to Expedite (Member Requests Only)- If the delegate decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the expedited request and provide written notice within 3 calendar days of the oral notice.

The notice must explain that the request will be processed using the standard 14 day timeframe and inform the member of the right to file an expedited grievance if they disagree with the decision not to expedite, inform the member of the right to resubmit a request for expedited determination with any physician support and provide instructions about the grievance process and it's timeframes.

Note: Provider requests cannot be down-graded.

Written notice of an adverse determination in an expedited situation must be sent to the member according to the time frames established for the expedite process. Failure to send this notice within the time frames constitutes a denial. All member denial notices, whether expedited or non-expedited, will inform the member of his or her right to reconsideration, including expedited. In addition, the denial notice will inform the member about the expedited appeals process and how to use it.

Procedure:
The following is the process for the Expedited Review of Initial Determinations.

- Member or member representative makes a request for expedited review (written or oral).

- Requests will be reviewed by the Health Plan/IPA (as designated) to determine if they meet criteria for expedited review. Requests that do not meet criteria will be handled within normal time frames for authorization requests.
- Follow up letter is sent to the member within two working days of oral notification.
- The Health Plan will communicate its determination to the member and the members' physician within the time frames established, Information conveyed to member must include:
    i) Initial determination; or
    ii) Need to gather additional information or consult a specialist; or
    iii) Decision to handle the request in a non expedited manner.
- An extension to reach a determination is permitted if the plan determines that additional information is necessary and the delay is in the best interest of the member or if the member requests additional time to provide information that the member believes will support his/her request.
- The provider and member will be sent a confirmation of the decision in writing within of the regulatory time period allowed for making the decision.

Expedited Reconsideration (Appeals)

Policy:
A member or their authorized representative (including M.D.) may make requests for expedited determinations (orally or written). An expedited initial determination is not a prerequisite to an expedited appeal. An expedited appeal may be granted even if a prior request for expedited determination was denied. If the member's request for expedited appeal is supported by the Health Plan's Medical review, the Health Plan is obligated to process the request in the expedited time frame. This appeals process does not apply to denials of payment.

Processes for oral requests, physician requests and time frames are the same as for initial determinations. (see policy for initial determinations). If the denial issued by Santé is upheld by the Health Plan the members file and a written explanation will be forwarded by the Health Plan to the QIO (Quality Improvement Organization) within 24 hours of the decision. If the Health Plan does not rule on the appeal within the regulatory timeframe or an appropriate extension of the time frame for expedited appeals the appeal is considered upheld and the file must be forwarded to the QIO.

Procedure:
The following is the process for the Expedited Reconsideration (Appeals)

1. Member or member representative makes a request for expedited reconsideration (written or oral).

2. If request made to Santé the request will be forwarded to the Health Plan with all applicable information within the same day.

3 If the request is made to the Health Plan, upon receipt of request for information to substantiate initial determination, Santé will forward required information to health plan in an expeditious manner.

4. The Health Plan will send a written acknowledgement of all expedited appeals within 3 days of receipt.

5. Requests will be reviewed by the Health Plan/IPA (as designated) to determine if they meet criteria for expedited review. Requests that do not meet criteria will be handled within normal time frames for appeal requests.

6. If the Health Plan upholds initial denial of Santé, file is forwarded by the Health Plan to the QIO.

SANTÉ PHYSICIANS IPA

Policy/Procedure

HOSPITAL ADMISSIONS TRACKING

Policy: 2.20
Origination Date: 07/1995
Last Review Date: 01/2024

Purpose:

The Utilization Management staff will assist in the accurate tracking of hospital admissions.

Policy:

Hospital admissions for Santé members will be entered in the computer or logged by designated UM staff and the data will be forwarded to the appropriate licensed staff member for the implementation of the concurrent review process.

Procedure:

1. Hospital Demographic/or request forms are received from hospitals to inform the UM staff of hospital admissions for Santé Physicians IPA members.

2. The staff documents the following information regarding the hospital admission:

    - Member's name
    - Date of admission
    - Location of admission
    - Diagnosis
    - Name of Primary Care Physician
    - Name of Admitting Physician
    - Admission through Emergency Department (if applicable)
    - Eligibility and Benefits

3. The information is forwarded to the UM nurse who will be responsible for concurrent review.

4. According to the contract, health plan staff will be notified appropriately of all hospital admissions (see concurrent review process).

5. Out of Area/Out of Plan Admission: Intensity guidelines: Out of area/out of plan admissions are reviewed on priority basis to facilitate transfer to contracted

facility when clinically stable. The Medical Director reviews clinical information as needed.

a. The Health Plan is notified for all Out of Area/Out of Plan admission immediately.
b. The PCP is informed immediately following notification from out of area facilities of patient admission.

SANTÉ PHYSICIANS IPA

Policy/Procedure

OUT OF AREA/OUT OF PLAN ADMISSION
(Transfer Protocol)

Policy: 2.21
Origination Date: 7/1995
Revision Date: 01/2024

Purpose:
The Utilization Management Staff will assist in the transfer of patients (if stable) to contracted facilities.

Procedure:

1. The admitting facility will notify Santé of the admission.

2. Health Plan will be notified.

3. The UM Nurse, upon notification, will obtain a review of the patient's status or refer case management to HMO patient management as determined by contractual arrangement.

4. If clinically stable as assessed by the attending physician, a transfer may proceed.

5. The Primary Care Physician (PCP) will be notified to: Confer with attending physician at OOA/OOP facility if necessary.
   a. Attend to the patient at the contracted facility following transfer.
   b. Refer to specialist if necessary.

6. UM Staff will determine bed availability.

7. Patient/family will be notified of need to receive care at appropriate facility.

8. If patient/family refuses appropriate transfer, a denial letter will be generated.

9. When a transfer is appropriate, the UR department will be notified of intent and for assistance.
   a. Coordination of transfer orders by attending physician.
   b. Coordination of transport with contracted provider.
      - If no contracted provider, CHCC authority may negotiate rates.

10. Receiving facility notified of intent to transfer and receive orders from admitting physician.

SANTÉ PHYSICIANS IPA

Policy/Procedure

Use of Social Security Numbers

Policy: 2.23
Origination Date: 04/2004
Last Review Date: 01/2024

Purpose:

The Utilization Management Department will not use Social Security Numbers of members for public display or correspondence.

Policy:

1. The Utilization Management staff will not publicly post or display an individual's Social Security Number in any manner.

2. Will not require an individual to transmit his/her Social Security Number over the Internet, unless the connection is secure or Social Security Number is encrypted.

3. Will not require an individual to use his/her Social Security Number to access the Internet web site, unless a password or unique personal identification number or other authentication is also required.

4. Will not print an individual's Social Security Number on any material that is mailed to the member (i.e., letter authorizing services), unless state or federal law requires the inclusion of the Social Security Number on the document to be mailed.

Procedure:

1. The Utilization Management staff will not have Social Security Numbers on any materials or correspondence going to physician's offices, members, or health plans.

2. For identification purposes, all correspondence will display only the last 4 digits (XXX-XX-1234).

SANTÉ PHYSICIANS IPA

Policy/Procedure

Modifying Authorizations

Policy: 2.24
Origination Date: 06/2006
Last Review Date: 01/2024

Purpose:
The Utilization Management staff will not rescind any authorizations. Modifying an authorization cannot occur within the Quick Cap system.

Policy:
The UM staff does not have the ability to make any changes to existing authorizations, for specific types of treatment, by a provider after services have been rendered.

Procedure:
The Quick Cap system is locked for all modifications of authorizations. UM Staff are not able to make any modifications to authorizations that have a final decision whether approved, modified or denied.

If authorization needs to be dismissed or withdrawn, Santé Management will follow policy 2.27 Dismissal and Withdrawal policy.

SANTÉ PHYSICIANS IPA

Policy/Procedure

Critical Incident Reporting and Tracking

Policy: 2.25
Origination Date: 12/2017
Effective Date: 01/2024

Purpose:
To ensure that critical incidents are reported and tracked.

Critical incidents must be reported to the appropriate agency and to the Health Plan.

What is a critical Incident?
A "Critical Incident" is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member

This can be but not limited to the following:

- Abuse
- Neglect
- Exploitation
- Suicide attempts
- Restraints
- Seclusion
- * Death of the member
- * Disappearance of the member
- * Rights Violations
- * Serious injury
- * Missing person
- * Medical Errors

Policy:
It is the policy of Santé Physicians to report and track and trend all critical incidents.

Procedure:

1. All critical incidents will be logged for the purpose of tracking and trending critical incidents.
2. All critical incidents will be collected, tracked and reported to health plans.
3. Critical Incident reports will be submitted monthly.
4. The following can report a critical incident:
   - UM Staff
   - QM Staff
   - Pharmacy Staff
   - Provider office staff
   - * Providers
   - * Members
   - * Family
   - * Caregivers
   - * Any Community Based Services
   - * Hospitals

SANTÉ PHYSICIANS IPA

Policy/Procedure

Adverse Events, Hospital Acquired Conditions, and Never Events

Policy: 2.25a
Origination Date: 01/2022
Effective Date: 01/2024

Purpose:

To increase the awareness of events that impact patient safety through identification and referral of Adverse Events (AE), Hospital Acquired Conditions (HAC) and Never Events (NE). The reporting process provides a mechanism for delegates to accurately document and report Adverse Events, Hospital Acquired Conditions and Never Events to meet Health Plan requirements, as applicable.

This process promotes a consistent and standardized reporting method to:

–help support Health Plan quality oversight processes,

–identify quality improvement opportunities,

–track and trend providers, and

–comply with applicable regulatory requirements and accreditation standards.

Procedure:

Adverse Event (AE):

•Is an occurrence that negatively impacts the expected outcome of care. These are potentially avoidable issues through:

appropriate patient management, patient compliance, proper technical performance and/or proper medical and nursing staff coordination of care.

•They are serious/egregious events as defined by Centers for Medicare& Medicaid Services (CMS) and National Quality Forum (NQF).

Hospital Acquired Condition (HAC):

•Is a condition that the patient *does not have when admitted to the hospital*, but develops during the *current* hospital stay and could have reasonably been prevented if the hospital had followed evidence-based guidelines.

Never Event (NE):

•Is an adverse event that is devastating, unacceptable, and often results in litigation

Wrong surgical patient, Wrong surgical site, Wrong procedure

If an Adverse Event has been identified Sante will utilize the CA Adverse Event Reporting form. This form is located J:\UM\Adverse Events. Below are the instructions to follow.

CA Adverse Event Reporting Form Instructions

Purpose:

The CA HMO Adverse Event Reporting Form will provide quality oversight and subsequent quality improvement efforts to meet regulatory, accreditation and health plan requirements. It will provide a mechanism for delegates to accurately report Adverse Events, Never Events and Hospital Acquired Conditions and support the health plans ability to track and trend providers. The form will also enable delegates to report in a consistent and standardized method.

Procedure:

A. Completion of Form:

1. Date Submitted - Enter the date the form was submitted to the Health plan using the dropdown calendar in the hyperlink.
2. Submitted by - Enter the name and title of the person completing the form.
3. Submitter phone number - Enter the phone number of the person completing the form. This will assist the health plan if additional information is needed.
4. Date of Event - Enter the date the event occurred using the dropdown calendar in the hyperlink.
5. Case/Authorization # - Enter the case or authorization number used to identify the provider/facility where the event occurred. This should be a unique identifier that can be easily referenced.
6. Member/Patient ID Number - Enter the health plan ID number for the member/patient. This should not be the social security number.
7. Member/Patient Last Name - Enter the last name of the member/patient.
8. Member/Patient First Name - Enter the first name of the member/patient.
9. Provider Type - Choose the provider type from the dropdown list (i.e., hospital, SNF, ambulatory surgical center, etc.)
10. Provider Name - Enter the name of the provider associated with the event.
11. Delegate Name - Enter the name of the Delegate.
12. Street Name - Enter the street name of the hospital where the event occurred, as applicable.
13. Date of admission - Enter the date the member/patient was admitted to the applicable facility using the dropdown calendar in the hyperlink.

    Please select only one of the following categories

14. Adverse Event - Choose the applicable Adverse Event in the dropdown hyperlink. If selecting an option for Adverse Event, Select "*Does not apply"* for Never Event and Hospital Acquired Condition.
15. Never Event - Choose the applicable Never Event in the dropdown hyperlink. If selecting an option for Never Event, Select "*Does not apply"* for Adverse Event and Hospital Acquired Condition.
16. Hospital Acquired Condition - Choose the applicable Hospital Acquired Condition in the dropdown hyperlink. If selecting an option for HAC, Select "*Does not Apply" for* Adverse Event and Never Event.

17. Brief Summary of Event - Enter a brief description of the event in the comment section including the status of the member's/patient's condition at the time of reporting the event.

B. Submission of Form:

1. Completed forms should be submitted to the appropriate health plan for investigation using the contact information and email address noted for each health plan.

SANTÉ PHYSICIANS IPA

Policy/Procedure

SITE OF SERVICE

Policy: 2.26
Origination Date: 09/2021
Last Review Date: 01/2024

Purpose:

Ambulatory Surgery Centers (ASC) offer outpatient surgical services to members in an environment appropriate for low risk procedures in members with low risk health status. Santé members may choose to receive medically indicated surgical procedures in lower cost ASC level of care. In order to assist in managing the utilization of appropriate site of service for specific outpatient surgical procedures, Santé Physicians conducts medical necessity reviews for outpatient surgical services when requested in an outpatient hospital department instead of an ASC.

Policy:

Certain planned surgical procedures requiring enhanced monitoring and care and performed in a hospital outpatient department are considered medically necessary for an individual who meets any of the following criteria:

- Advanced liver disease (MELD Score > 8)
- Advance surgical planning determines an individual requires overnight recovery and care following a surgical procedure
- Anticipated need for transfusion
- Anticoagulation Therapy
- Bleeding disorder requiring replacement factor or blood products or special infusion products to correct a coagulation defect
- BMI >40
- Brittle Diabetes
- Cardiac arrhythmia (symptomatic arrhythmia despite medication) or implanted pacemaker or cardioverter-defibrillator
- Chronic heart failure (NYHA Class III or IV)
- Chronic obstructive pulmonary disease (COPD) (FEV1 <50%)
- Coronary artery disease ([CAD]/peripheral vascular disease [PVD]) (ongoing cardiac ischemia requiring medical management or recently placed [within 1 year] drug eluting stent)
- Developmental stage or cognitive status warranting use of a hospital outpatient department
- End stage renal disease ([hyperkalemia above reference range] receiving peritoneal or hemodialysis)
- History of Anesthesia complications or malignant hyperthermia

- History of cerebrovascular accident (CVA) or transient ischemic attack (TIA) (recent event [< 3 months])
- History of myocardial infarction (MI) (recent event [< 3 months])
- Illicit drug abuse
- Individuals with drug eluting stents (DES) placed within one year or bare metal stents (BMS) or plain angioplasty within 90 days unless acetylsalicylic acid and antiplatelet drugs will be continued by agreement of surgeon, cardiologist and anesthesia
- Major blood vessel procedures or anticipated major blood loss
- Ongoing evidence of myocardial ischemia
- Poorly Controlled asthma (FEV1 < 80% despite medical management)
- Pregnancy
- Prolonged surgery (> 3 hours) or recovery time >10 hours
- Resistant hypertension (Poorly Controlled)
- Severe valvular heart disease
- Sleep apnea (moderate to severe Obstructive Sleep Apnea (OSA)
- Under 18 years of age

A planned surgical procedure not meeting the above criteria should be redirected from a hospital outpatient setting to an appropriate ASC.

A planned surgical procedure performed in a hospital outpatient department will **NOT** be considered medically necessary if there is an inability to access an ambulatory surgical center for the procedure due to any one of the following:

- There is no geographically accessible ambulatory surgical center available at which the individual's physician has privileges

Digestive Screening Procedures -Site of Service Documentation Requirements

CPT/HCPCS Codes	Required Clinical Information
Colonoscopy 45378, 45380, 45381, 45384, 45385,G0105, G0121 EGD 43235, 43236, 43237, 43238, 43239	If the location being requested is an outpatient hospital, provide medical notes documenting the following: • History relative to procedure • Co-morbidities necessitating outpatient hospital setting • Physical examination, including patient weight • Planned procedure

Planned Surgical Procedures -Site of Service Documentation Requirements

CPT/HCPCS Codes	Required Clinical Information
Refer to Outpatient Surgical Procedures list	Medical notes documenting all of the following: • History • Physical examination including patient weight and co-morbidities • Surgical Plan • Physician privileging information related to the need for the use of the hospital outpatient department • American Society of Anesthesiologists (ASA) score, as applicable

SANTÉ PHYSICIANS IPA

Policy/Procedure

Medicare Dismissal and Withdrawal

Policy: 2.27
Origination Date: 06/2022
Last Review Date: 01/2024

Purpose:

Centers for Medicare & Medicaid Services (CMS) process for dismissals and withdrawals by Medicare Advantage organizations, Applicable Integrated Plans (AIPs) and Part D plans is included the organization determination process. These provisions apply to organization determinations, coverage determinations, reconsiderations and redeterminations to include dismissals and withdrawals. A dismissal is a decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements. A withdrawal is can be a verbal or written request to rescind or cancel a grievance, initial determination, or appeal.

Policy:

Dismissing a request: Santé UM Department dismisses a request, either entirely or for any stated issue, under any of the following circumstances:

- The individual or entity making the request is not permitted to request an organization determination.
- The plan determines the party failed to make a valid request.
- An enrollee or the enrollee's representative files a request, but the enrollee dies while the request is pending, and both of the following apply:
    - — The enrollee's surviving spouse or estate has no remaining financial interest in the case
    - — No other individual or entity with a financial interest in the case wishes to pursue the request
- A party filing the request submits a timely withdrawal request

The death of the enrollee, alone, is not sufficient to dismiss a request. There must also be no remaining financial interest of the enrollee’s spouse or estate in the case. Additionally, there must not be no other individual or entity with a financial interest in the case that wishes to pursue the organization determination or coverage determination. CMS interprets having a financial interest in the case as having financial liability for the item(s) or service(s) underlying the coverage request.

Code of Federal Regulations (CFR) 42 dismissal notice requirements (all dismissals). Notice of dismissal: Santé must mail or otherwise transmit a written notice of the dismissal of the request to the parties, including applicable appealable rights. The notice must state all the following:

1. The reason for the dismissal
2. The right to request that the plan vacate the dismissal action
3. The right to request reconsideration of the dismissal

Vacating a dismissal – A dismissal may be vacated by the entity that issued the dismissal request (that is, Medicare Advantage organizations, AIP, Part D plan sponsors and the Independent Review Entity) if good cause for doing so is established within 6 months of the date of the dismissal notice.

Effect of dismissal – The dismissal of a request is binding unless it is modified or reversed by the Medicare Advantage organization, AIP, or Part D plan sponsor, as applicable, upon reconsideration or vacated.

Withdrawals – Specify that a party can make a request to withdraw at any time before the decision is issued. CMS modified the proposed provisions to permit both verbal and written withdrawal requests for organization determinations, coverage determinations, reconsiderations and redeterminations.

Scenarios not considered dismissals:

• **Incomplete clinical information after outreach attempts.** Delegates should make the best decision based on information available and could include denial for lack of information outlining what information is needed to approve coverage.

• **Service that does not require prior authorization.** Delegates should either administratively approve the service or reach out to health care professionals and verify if they want to withdraw the request. If the health care professional does not want to withdraw, then administratively approve the service.

• **Duplicate service requests.** Delegates should call health care professionals to verify duplicate request and cancel the case

Dismissal appeal reviews completed by Health Plan

• Dismissal overturn notification from a Health Plan appeal serves as the new received date and time to process the initial requested service that was dismissed according to the applicable service turnaround time frame.

SANTÉ PHYSICIANS IPA

Policy/Procedure

Provider Administered Drugs-Site of Care Home

Policy: 2.28
Origination Date: 05/2023
Last Review Date: 01/2024

Coverage Rationale:

This policy addresses the criteria for consideration of allowing intravenous medication infusion in alternate sites of care other than the home setting.

Policy:

Home Infusion services are well accepted places of service for medication infusion therapy. For members that cannot receive infusions in the preferred home setting AND meet one of the following criteria points, drug administration may be performed at a hospital outpatient infusion center, physician office or independent infusion center.

Documentation that the individual is medically unstable for administration of the prescribed medication in the home setting as determined by any of the following:

- The individual's complex medical status or therapy requires enhanced monitoring and potential intervention above and beyond the capabilities of the home infusion setting; or
- The individual's documented history of significant comorbidity (e.g., cardio pulmonary disorder) or fluid overload status that precludes treatment in the home setting; or
- Outpatient treatment in the home setting presents a health risk due to a clinically significant physical or cognitive impairment; or
- Difficulty establishing and maintaining patient vascular access; or
- Documentation (e.g., infusion records, medical records) of episodes of severe or potentially life threatening adverse events (e.g., anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other pre-medications, thereby increasing risk to the individual when administration is in the home setting; or
- Homecare of infusion provider has deemed that the individual, home caregiver or home environment is not suitable for home infusion.

This policy applies to these specialty medications that require healthcare provider administration and appropriate for home infusion:

Specialty Medication	HCPC Code
Remicade	J1745
Inflectra	Q5103
Renflexis	Q5104
Entyvio	J3380
Stelara	J3357/J3358
Sandostatin	J2354
Panzyga	J1576
Privigen	J1459
Octagam	J1568
Gammagard	J1569
Gammaked/Gammunex	J1561
Bivigam	J1556
Krystexxa	J2507
Ocrevus	J2350
Glassia	J0257
Avsola	Q5121

SANTÉ PHYSICIANS IPA

Policy/Procedure

TRANSPLANT DATA

Policy: 3.01
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose

The Santé Physicians IPA and health plan staff work collaboratively to manage the care of the Transplant candidate. Health plans must be notified of potential cases and referrals or authorizations issued by Santé as needed.

Policy

Santé will follow each health plan's transplant contract and criteria as it relates to documentation and reporting of transplant cases.

Procedure

1. Santé will notify the Health Plan within 1 business day to determine Centers of Medical Excellence/Plan Approved Trans Center Network Use

2. The Health Plan will be notified of all transplant-related admissions within 2 business days. Notification will be documented in the case management file.

3. Other responsibilities:
   - Issuing the pend/deferral letter if clinical information is missing
   - Advising members regarding utilization of Centers of Medical Excellence
   - Issuing denial letters for benefit limitation, out-of-network providers/practitioners, lack of medical necessity after medical review
   - Documentation of concurrent review, discharge planning, case management member needs.
   - Negotiating fee arrangements for the professional component of the transplant if a non-participating Transplant Center is required
   - Notification of approval for the actual transplant and the transplant admission after medical approval by the Health Plan
   - Provider referrals and authorizations for all pre-and-post transplant services.
   - Transplant related investigational/experimental services for members will be referred to the Health Plan and not approved or denied by Santé.
   - All clinical trials are considered investigational/experimental

SANTÉ PHYSICIANS IPA

Policy/Procedure

PROVIDER PROFILING

Policy: 3.02
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
Individual Santé provider performance is reviewed in order to give the Utilization Management Committee and each physician provider a greater understanding of use of medical resources, quality/consistence of such utilization.

Scope:
Utilization statistics are accumulated on the individual providers. The information is reviewed to determine whether services have been utilized appropriately. Santé approved practice guidelines, health plan report cards, and national statistics are included in the comparative data analysis process. The data analysis takes into consideration risk adjustments that reflect case mix, type and severity of the member/patient illness and age categories of member/patient (pediatric/commercial/Medicare).

The data analysis used for economic profiling of providers is shared with the individual providers upon request. This information is available to the provider up to 60 days after contract termination.

Education is implemented as necessary.

See
Policy 3.03 Utilization Management Interface with Quality Improvement
Policy 3.04 Utilization Management Reports
Policy 3.05 UM/Finance Reports

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT INTERFACE WITH QUALITY IMPROVEMENT

Policy: 3.03
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
The Utilization Management Committee recognizes that in order for the Utilization Management Program to be successful, there must be an active interrelationship with Quality Improvement.

Policy:

1. The Utilization Management Committee will work with the Quality Improvement Committee to identify, resolve, and monitor issues of concern related to the utilization and quality of services that are managed by the Santé Physicians IPA.

2. The UM and QI Committees' overlapping activities, analyses, and reporting will be documented in the meeting minutes.

3. The Utilization Management Committee Minutes will be used to report to the Santé Physicians IPA Board of Directors significant utilization management and quality issues and activities.

Scope:
The Utilization Management Committee will interact with the Quality Improvement Committee to ensure that services delivered and managed by the Santé Physicians IPA providers, sub-delegates and staffs are high quality, appropriate, cost-effective, efficient, and accessible.

The following are issues which involve both quality and utilization management:

1. Cost of services in relation to provider performance
2. Accessibility of services
3. Appropriateness of care/services
4. Continuity of care
5. Member compliance and risk minimization
   a. Health education
   b. Health maintenance

6. Santé Physicians IPA compliance with regulations, standards, and HMO requirements.
7. Documentation of prospective hospitalization review including:
    a. Admission diagnosis
    b. Pre-admission work-up
    c. Necessity of admission
    d. Assignment of authorized services
8. Reporting of concurrent review and discharge planning.
    a. Length of stay reports which are based on severity of illness, intensity of service, and communication between the utilization management nurse and attending physician (and Medical Director as appropriate).
9. Analysis reporting of costs and services which have been retrospectively reviewed.
10. The retrospective review reports reflect (as necessary)-
    a. Problems identified
    b. Corrective action plan developed
    c. Action plan implemented
    d. Quality management process followed

11. Problem areas which are specific to the different types of practice.
12. Peer review process implementation as necessary.
13. Emergency room visits and service analysis which includes-
    a. Actual emergency - according to criteria and individual assessment
    b. Appropriate contacts made to obtain authorization
    c. Specific authorization of services
    d. Authorization for limited service matches claim
    e. Appropriateness of treatment
    f. ER usage billed at urgent care rates as appropriate and data compared with urgent care utilization
14. Review of urgent care services shows verification of:
    a. Actual urgent care situation according to criteria and individual assessment
    b. Appropriate contacts made to obtain authorization
    c. Authorizations are narrowly framed
    d. Limited service authorization is matched to claim
    e. Clinical data is compared with ER utilization
15. Radiology testing screened for:
    a. Repeat of same x-rays
    b. Difference in film interpretations of provider and radiologist
    c. Appropriate ordering of x-rays
16. Ambulatory Surgery
    a. Surgery is clinically justified
    b. Admission to hospital as a result of complications
    c. Infection rates
17. Member compliance with recommended treatment regimen

18. The clinical management of chronic conditions such as diabetes, hypertension, and upper respiratory infections

19. Appropriate recommendations for surgery
20. Hospitalizations which are not indicated
21. Appropriate laboratory testing
22. Allergy testing and treatment
23. Specialty care referrals which reflect-
    a. Appropriate clinical indication
    b. Appropriate authorization for specific visits and/or services

The following sources may provide useful data for analyzing compliance with utilization and quality standards:

24. Appointment logs which provide information on-
    a. Member access to service
    b. The telephone triage system
25. Laboratory and x-ray reports including provider follow-up documentation
26. Health plan formulary utilization reports for prescription medications
27. Reports on-
    a. Hospitalization information
    b. Member claims
    c. Staffing patterns
    d. Referral patterns
    e. Cost center reports
    f. Ancillary service utilization
    g. Outpatient data
    h. Prescription logs
    i Member complaints/grievances
    j. Staff interviews/suggestions
    k. Provider surveys
    l. Satisfaction surveys
    m. Time studies
    n. Observation studies
    o. Peer review
    p. Provider profiles
    q. Infection control data
    r. Performance appraisals
    s. Incident report

SANTÉ PHYSICIANS IPA

Policy/Procedure

UTILIZATION MANAGEMENT REPORTS

Policy: 3.04
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
The Utilization Management Committee reviews statistical reports of utilization data. The UM Committee then makes any necessary recommendations for improving the structure of the utilization management program.

Scope:
The following list is an example of, but not limited to, the information analyzed by the UM Committee:

1. Enrollment data is reported and reviewed on the basis of member months.

2. Dis-enrollment data is reported and reviewed on the basis of covered lives and enrollees in each contracted health plan.

3. Third party liability cases are reported

4. Coordination of benefits cases are reported

5. Inpatient report reviews consist of:
   a. Hospital discharges
   b. Average length of stay
   c. Average cost information

6. Inpatient utilization reports may be summarized in categories such as:
   a. Total general hospital services
   b. Acute care services
   c. Medicine
   d. Surgery
   e. Maternity & OB/GYN
   f. Newborns & Neonates
   g. Psychiatry/Psychology

7. Case management cases including end stage renal disease, transplant by type, catastrophic, and hospice care cases are reported.

8. Inpatient non-acute care data may be reported on:
    a. Rehabilitation facility
    b. Skilled nursing facility
    c. Transitional care or respite facility.

9. Ambulatory care data may be presented in categories such as:
    a. Outpatient services
    b. Emergency room services
    c. Ambulatory surgery cases
    d. Mental health services

10. Chemical dependency services for both inpatient and outpatient utilization are reviewed.

11. Outpatient Drug Utilization Reports

    a. Health plan reports on the total cost of prescriptions per member per month and annual total of prescriptions per member per year are reviewed.
    b. Report of drugs prescribed utilizing the health plan formulary.

SANTÉ PHYSICIANS IPA

Policy/Procedure

Medicare Part C Organization Determinations, Appeals, and Grievances (ODAG) Audit Process and Data Request

Policy: 3.04a
Origination Date: 07/2020
Last Review Date: 01/2024

Purpose:
Medicare health plans require the preparation and submission of monthly Part C Organization Determination, Appeals, and Grievances (ODAG) reports also known as Universes.

Scope:
The universes collected for this program area test whether the sponsor has deficiencies related to timeliness, clinical decision making and appropriateness, dismissals and grievances and the misclassification of requests in the area of ODAG.

Universe Preparation & Submission

1. Responding to Universe Requests: The sponsor is expected to provide accurate and timely universe submissions within 15 business days of the engagement letter date. CMS may request a revised universe if data issues are identified. The resubmission request may occur before and/or after the entrance conference depending on when the issue was identified. Sponsors will have a maximum of 3 attempts to provide complete and accurate universes, whether these attempts all occur prior to the entrance conference or they include submissions prior to and after the entrance conference. However, 3 attempts may not always be feasible depending on when the data issues are identified and the potential for impact to the audit schedule. When multiple attempts are made, CMS will only use the last universe submitted.

If the sponsor fails to provide accurate and timely universe submissions twice, CMS will document this as an observation in the sponsor's program audit report. After the third failed attempt, or when the sponsor determines after fewer attempts that they are unable to provide an accurate universe within the timeframe specified during the audit, the sponsor will be cited an Invalid Data Submission (IDS) condition relative to each element that cannot be tested, grouped by the type of case.

2. Pull Universes: The universes collected for this program area test whether the sponsor has deficiencies related to timeliness, clinical decision making and appropriateness, dismissals and grievances and the misclassification of requests in the area of ODAG. The sponsor will provide universes of all of its organization determinations (both payment and pre-service, both expedited and standard), all sponsor reconsiderations (both payment and pre-service, both expedited and standard), all requests for direct member reimbursement, all IRE, ALJ and MAC cases that required effectuation, all expedited and standard grievances, as well as a call log of all calls received by the sponsor from enrollees or their representatives relating to their Part C benefit.

Instructions for what should be included in each universe are listed above the tables listed in Appendix A. For each respective universe, the sponsor should include all cases that match the description for that universe for all contracts and Plan Benefit Packages (PBPs) in its organization as identified in the audit engagement letter (e.g., all standard ODs for all contracts and PBPs in your organization).

The universes should be 1) all inclusive, regardless of whether the request was determined to be favorable, partially favorable, unfavorable, auto-forwarded or dismissed and 2) submitted in the appropriate record layout as described in Appendix A. Please note that for audit purposes, partially favorable decisions are treated as denials. These record layouts include:

- Table 1: Standard Pre-Service Organization Determinations (SOD)
- Table 2: Expedited Pre-Service Organization Determinations (EOD)

3. Submit Universes to CMS: Sponsors should submit each universe in the Microsoft Excel (.xlsx) file format with a header row (or Text (.txt) file format without a header row) following the record layouts shown in Appendix A, Tables 1-14. The sponsor should submit its universes in whole and not separately for each contract and PBP.

4. Timeliness Tests: CMS will run the tests indicated below on each universe except for Table 14: Call Logs Part C. For the effectuation tests, auditors will determine percentage of timely cases from a sponsor's approvals (favorable cases). For the notification timeliness tests, auditors will determine the percentage of timely cases from a full universe of approvals and denials.

TABLE #	RECORD LAYOUT	UNIVERSE	COMPLIANCE STANDARD TO APPLY	CHAP. 13 REF.	TEST
1	SOD	Standard Pre-service ODs	No later than 14 days, plus 14 days (totaling 28 days) if an extension is used.	§ 40.1	Decision-Making
					Notification
2	EOD	Expedited Pre-service ODs	No later than 72 hours, plus 14 days (totaling 17 days) if an extension is used.	§ 50.1 § 50.2 § 50.4	Decision-Making
					Notification

Audit Elements

I. Timeliness - Organization Determinations, Appeals and Grievances (TODAG)

(Performed via webinar prior to the entrance conference, results communicated to sponsor during live portion of the audit)

1. **Select Sample Cases:** CMS will randomly select 5 cases from record layouts 1 through 13 for a total of 65 cases. CMS will not validate the Call Logs Part C universe (Table 14) during this pre-audit webinar.

2. **Verify Universe Submission:** Prior to the live portion of the audit, CMS or its contractor, when applicable, will schedule a separate webinar with the sponsor to verify that the dates and times provided in the universe submissions are accurate. The sponsor should have available the information and documents necessary to demonstrate that the dates and times provided in the record layouts were accurate. The sponsor will need access to the following documents during the live webinar and CMS may request the sponsor to produce screenshots of any of the following:

2.1. For requests for organization determinations or reconsiderations:

- Original pre-service or payment (i.e., claim) or reconsideration request.
- Letters, emails or documentation confirming the sponsor's receipt of the request:
    - If request was received via fax/mail/email, copy of original request including date/time stamp of receipt.
    - If request was received via phone, copy of Customer Service Representative (CSR) notes and/or documentation of call including date/time stamp of call and call details.
- Description of the service/benefit requested from the provider/physician or the enrollee.
- Notices, letters, call logs or other documentation showing the sponsor requested additional information (if applicable) from the requesting provider/physician, including date, time, and type of communication. If the request was made via phone call, copy of the call log detailing what was communicated to the physician/provider.
- All supplemental information submitted by the requesting provider/physician or enrollee, including documentation showing when information was received by the sponsor.
    - If information was received via fax/mail/email, copy of original request including date/time stamp of receipt.
    - If information was received via phone, copy of CSR notes and/or documentation of call including date/time stamp of call and call details.
- Documentation of case review steps including name and title of final reviewer; rationale for denial; any reference to CMS guidance, Federal Regulations, clinical criteria, peer reviewed literature (where allowed), and sponsor documents (e.g., Evidence of Coverage (EOC)); or any other documentation used when considering the request.
- Documentation of effectuation including approval in organization determinations/reconsiderations systems and evidence of effectuation in sponsor's claims adjudication system, clearly showing date and time override was entered.
- Documentation showing approval notification to the enrollee and/or their representative and physician/provider, as applicable.
    - Copy of the written decision letter and documentation of date/time letter was printed and mailed.
    - If oral notification was given, copy of CSR notes and/or documentation of call including date/time of call.
- Records indicating that payments were made/issued such as Electronic Fund Transfer (EFT) records.
- Documentation showing denial notification to the enrollee and/or their representative and provider/physician, if applicable:
    - Copy of written decision letter and documentation of date/time letter was printed and mailed;
    - If oral notification was given, copy of CSR notes and/or documentation of call including date/time of call.
- If applicable, all documentation to support the sponsor's decision to process an expedited request under the standard timeframe, including any pertinent medical documentation, and any associated notices provided to the enrollee and the requesting provider/physician.
- If a reconsidered case was untimely, include the following:
    - Documentation showing when the sponsor auto-forwarded the request to the IRE.

Appendix

Appendix A—Organization Determinations, Appeals and Grievances (ODAG) Record Layouts

The universes for the Part C Organization Determination, Appeals and Grievances (ODAG) program area must be submitted as a Microsoft Excel (.xlsx) file with a header row reflecting the field names (or Text

(.txt) file without a header row). Do not include additional information outside of what is dictated in the record layout. Submissions that do not strictly adhere to the record layout will be rejected.

Please use a comma (,) to separate multiple values within one field if there is more than one piece of information for a specific field. Please ensure that all cases in your universes are populated based on the time zone where the request was received.

If you do not have data for any of the fields identified below, please discuss that with your Auditor in Charge (AIC) prior to populating or submitting your universes.

Note: There is a maximum of 4,000 characters per record row and spaces count toward this 4,000 character limit. Therefore, should additional characters be needed for a variable, enter this information on the next record at the appropriate start position.

Table 1: Standard Pre-service Organization Determinations (SOD) Record Layout

- Include all requests processed as standard pre-service organization determinations, including all supplemental services, such as dental and vision, and include all approvals and denials.
- Exclude payment requests, dismissals, reopenings, withdrawn requests and all requests processed as expedited organization determinations.
    - Note: The following exclusions were added after the 30-day comment period: requests for extensions of previously approved services, concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions. If sponsors have already programmed their systems to include these requests in this universe we will accept the universe submission.
- Submit cases based on the date the sponsor's decision was rendered, or should have been rendered (the date the request was initiated may fall outside of the review period).
- If a standard pre-service organization determination includes more than one service include all of the request's line items in a single row and enter the multiple line items as a single organization determination request.

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
C	Cardholder ID	CHAR Always Required	20	Cardholder identifier used to identify the beneficiary. This is assigned by the sponsor.
D	Contract ID	CHAR Always Required	5	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.

F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the sponsor for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
Column ID	**Field Name**	**Field Type**	**Field Length**	**Description**
G	Who made the request?	CHAR Always Required	3	Indicate whether the pre-service request was made by a contract provider (CP), non-contract provider (NCP), beneficiary (B) or beneficiary's representative (BR). Note: the term "provider" encompasses physicians and facilities.
H	Provider Type	CHAR Always Required	3	Indicate whether the provider performing the service is a contract provider (CP) or non-contract provider (NCP).
I	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2015/01/01).
J	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
K	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the pre-service request was denied.
L	Level of service	CHAR Always Required	50	Provide the level of service requested (e.g., inpatient/outpatient/ER/urgent care/point of sale transaction).
N	Request for expedited timeframe	CHAR Always Requested	3	If a request was made after the organization determination to expedite the request, indicate who made the subsequent request to expedite the request: non-contract provider (NCP), beneficiary (B), beneficiary's representative (BR). Answer NA if no expedited timeframe was requested.
O	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the sponsor extended the timeframe to make the organization determination.
P	If an extension was taken, did the sponsor notify the member of the reason(s) for the delay and of their right to file an expedited grievance?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the sponsor notified the beneficiary of the delay. Answer NA if no extension was taken.

M	Was request made under the expedited timeframe but processed by the plan under the standard timeframe?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the request was made under an expedited timeframe but was processed under the standard timeframe.

Column ID	Field Name	Field Type	Field Length	Description
Q	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. Sponsors should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
R	Date of sponsor decision	CHAR Always Required	10	Date of the sponsor decision. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Sponsors should answer NA for untimely cases that are still open.
S	Was the request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.
T	If denied for lack of medical necessity, was the review completed by a physician or other appropriate health care professional?	CHAR Always Required	2	Yes (Y)/No (N) indicator of review by a physician or other appropriate health care professional if request was denied for lack of medical necessity. Answer NA if the request was approved or not denied due to lack of medical necessity.
U	Date oral notification provided to enrollee	CHAR Always Required	10	Date oral notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA if no oral notification.
V	Date written notification provided to enrollee	CHAR Always Required	10	Date written notification provided to enrollee. The term "provided" means when the letter left the sponsor's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the sponsor's organization. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA if no written notification.
W	Date service authorization entered/effectuated in the sponsor's system	CHAR Always Required	10	Date service authorization entered in the sponsor's system. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA for denials.
X	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA if no AOR form was required.
Y	First Tier,	CHAR	70	Insert the name of the First Tier, Downstream,

	Downstream, and Related Entity	Always Required		and Related Entity that processed the standard pre-service organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

Table 2: Expedited Pre-service Organization Determinations (EOD) Record Layout

- Include all requests processed as expedited pre-service organization determinations, including all supplemental services, such as dental and vision, and include all approvals and denials.
- Exclude payment requests, dismissals, re-openings, withdrawn requests and all requests processed as standard organization determinations.
    - Note: The following exclusions were added after the 30-day comment period: requests for extensions of previously approved services, concurrent review for inpatient hospital and SNF services, post-service reviews, and notifications of admissions. If sponsors have already programmed their systems to include these requests in this universe we will accept the universe submission.
- Submit cases based on the date the sponsor's decision was rendered, or should have been rendered (the date the request was initiated may fall outside of the review period).
- If an expedited pre-service organization determination includes more than one service include all of the request's line items in a single row and enter the multiple line items as a single organization determination request.

Column ID	Field Name	Field Type	Field Length	Description
A	Beneficiary First Name	CHAR Always Required	50	First name of the beneficiary.
B	Beneficiary Last Name	CHAR Always Required	50	Last name of the beneficiary.
C	Cardholder ID	CHAR Always Required	20	Cardholder identifier used to identify the beneficiary. This is assigned by the sponsor.
D	Contract ID	CHAR Always Required	5	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the sponsor for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Who made the request?	CHAR Always Required	3	Indicate whether the pre-service request was made by a contract provider (CP), non-contract provider (NCP), beneficiary (B) or beneficiary's representative (BR). Note: the term "provider" encompasses physicians and facilities.
H	Provider Type	CHAR Always Required	3	Indicate whether the provider performing the service is a contract provider (CP) or non-contract provider (NCP).

Column ID	Field Name	Field Type	Field Length	Description
I	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Note: If the request was received as a standard organization determination request, but later expedited, enter the date of the request to expedite the organization determination.
J	Time the request was received	CHAR Always Required	8	Provide the time the request was received by your organization. Submit in HH:MM:SS military time format (e.g., 23:59:59). Note: If the request was received as a standard organization determination request, but later expedited, enter the time of the request to expedite the organization determination.
K	Diagnosis	CHAR Always Required	100	Provide the enrollee diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.
L	Issue description and type of service	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the expedited pre-service request was denied.
M	Level of service	CHAR Always Required	50	Provide the level of service requested (e.g., inpatient/outpatient/ER/urgent care/point of sale transaction).
N	Subsequent expedited request	CHAR Always Requested	3	If a request was made after the organization determination to expedite the request, indicate who made the subsequent request to expedite the request: contract provider (CP), non-contract provider (NCP), beneficiary (B), beneficiary's representative (BR) or sponsor (S). Answer NA if no subsequent expedited timeframe was requested.
O	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the Sponsor extended the timeframe to make the organization determination.
P	If an extension was taken, did the sponsor notify the member of the reason(s) for the delay and of their right to file an expedited grievance?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the sponsor notified the beneficiary of the delay. Answer NA if no extension was taken.

Column ID	Field Name	Field Type	Field Length	Description
Q	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. Sponsors should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
R	Date of sponsor decision	CHAR Always Required	10	Date of the sponsor decision. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Sponsors should answer NA for untimely cases that are still open.
S	Time of sponsor decision	CHAR Always Required	8	Time of the sponsor decision (e.g., approved, denied). Submit in HH:MM:SS military time format (e.g., 23:59:59). Sponsors should answer NA for untimely cases that are still open.
T	Was the request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.
U	If denied for lack of medical necessity, was the review completed by a physician or other appropriate health care professional?	CHAR Always Required	2	Yes (Y)/No (N) indicator of review by physician or other appropriate health care professional if the expedited pre-service request was denied for lack of medical necessity. Answer NA if request was approved or not denied due to lack of medical necessity.
V	Date oral notification provided to enrollee	CHAR Always Required	10	Date oral notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA if no oral notification.
W	Time oral notification provided to enrollee	CHAR Always Required	8	Time oral notification provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no oral notification.
X	Date written notification provided to enrollee	CHAR Always Required	10	Date written notification provided to enrollee. The term "provided" means when the letter left the sponsor's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the sponsor's organization. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA if no written notification was provided.
Y	Time written notification provided to enrollee	CHAR Always Required	8	Time written notification provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no written notification was provided.
Z	Date service authorization entered/effectuated in the sponsor's system	CHAR Always Required	10	Date service authorization was entered in the sponsor's system. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA for denials.

Column ID	Field Name	Field Type	Field Length	Description
AA	Time service authorization entered/effectuated in the sponsor's system	CHAR Always Required	8	Time service authorization entered in the sponsor's system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA for denials.
AB	AOR receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the sponsor. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA if no AOR form was required.
AC	AOR receipt time	CHAR Always Required	8	Time the Appointment of Representative (AOR) form or other appropriate documentation received by sponsor. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no AOR form was required.
AD	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the expedited organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

SANTÉ PHYSICIANS IPA

UTILIZATION/FINANCE STATISTICAL REPORTS

Policy: 3.05
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
Utilization and claims data is summarized in statistical reports that are reviewed by the Utilization Management Committee. The UM Committee utilizes the information as it develops strategic plans for the future operations of the Utilization Management Department and as it determines the direction of the Utilization Management Program.

Scope:
Data is accumulated from claims and utilization statistics to provide a comprehensive picture of the Santé Physicians IPA's effective utilization of services.

A summary of the statistical reports is presented to the Santé Physicians IPA at least on a quarterly basis.

The following lists are the items which may be reviewed by the UM Committee:

1. Report summaries show:
   a. The calculation of member months for any number of consecutive months up to twelve.
   b. The member months may be calculated according to:
      Primary Care Provider
      Contracted health plan
      Specific age/gender categories

2. Statistics that reflect specific utilization management information may show:
   a. Provider services including specialty care, hospital stays, protocols and primary case management through customized reports.
   b. Comparable treatment and costs of national and local data.
   c. Identification and tracking of high cost cases for coordination and continuity of care.
   d. Hospital census and discharge planning reports.
   e. Management and summary reports, utilization reports for inpatient and outpatient referrals which are integrated with claims data to show which ambulatory and hospital services are being used the most, by which providers and for which diagnoses.

Specialty Referral Tracking

In accordance to Title 28, CCR, Section 1300.70 (b)(2)(H) & (c); CA H&S Code 1367.01(h)(6)(j)

Quick Cap system is used for Commercial and Medi-CAL lines of business to provide authorizations and claims for provider requests and claims payment. Reports are generated from Quick Cap system to track and monitor referrals requiring prior authorization, including referrals to non-contracted providers.

- System tracking includes the following types of referrals: Authorized, Denied, Deferred, and Modified. Unused authorizations are identified based on linked claims and authorizations. Due to claims lag, this can be up to 9 months depending on line of business; Commercial and/or Medi-CAL.
- Monitoring timeliness of referrals is conducted on a day-by-day basis.
- Potential underutilization is monitored by linked claims/authorizations of open/unused referrals on a quarterly basis.
- Follow up of open/unused referrals to members is conducted on a quarterly basis via member letters.
- Specialty Referrals monitoring reports are submitted to health plans on a quarterly basis via ICE Work Plan to include:
    - Analysis and identification of data based on claims and authorizations of specialty referrals.
    - Identification and follow up of open/unused authorizations
    - Member notification of potential underutilization based on open/unused authorizations

SANTÉ PHYSICIANS IPA

Policy/Procedure

CASE MANAGEMENT PROGRAM DESCRIPTION

Policy: 4.01
Origination Date: 7/1995
Last Revision Date: 01/2024

Purpose:
The purpose of the Santé case management program is to ensure that medically necessary care is delivered in the most cost-efficient setting for members who require extensive or ongoing services. The program will be focused on the delivery of cost-effective, appropriate healthcare services for members with chronic care needs.

Proactive clinical and administrative processes are implemented to identify, coordinate, and evaluate appropriate high quality services which may be delivered on an ongoing basis.

This case management process is directed at coordinating resources and creating appropriate cost-effective alternatives for catastrophically, chronically ill, or injured members on a case by case basis to facilitate the achievement of realistic treatment goals.

Scope:
Case managers will coordinate individual services for members whose needs include ongoing medical care, home health and hospice care, rehabilitation services, and preventive services. The case managers will work collaboratively with all members of the healthcare team, including discharge planners at the affiliated hospitals and case management staff at the contracted health plan offices. The Medical Director and Utilization Management Committee members will be involved in overseeing these case management functions.

Most cases are identified through inpatient concurrent reviews, authorizations, D2 analysis, but referrals are accepted from any source.

Policy:
The Santé case management program will accomplish the following:

1. Coordinate cost-effective services.

2. Monitor care that is easily accessible with no access barriers as related to the member's available benefits.

3. Apply benefits appropriately and coordinate with health plan staff to flex benefits.

4. Promote early and intensive treatment intervention in the least restrictive setting.

5. Create individualized treatment plans that are revised as the member's healthcare needs change.

6. Utilize multidisciplinary clinical, rehabilitative, and support services.

7. Arrange broad-spectrum appropriate resources for members.

8. Deliver highly personalized case management services.

9. Uphold strict rules of confidentiality.

10. Provide ongoing case management program analysis and development.

11. Encourage collaborative collegial approaches to the case management process.

12. Reward providers who stay current within mandated and Santé recommended guidelines.

13. Promote the case management program's viability and accountability.

14. Protect member rights and encourage member responsibility.

Procedure:
The following is the case management procedural process:

1. Santé staff, providers, hospital staff, employers, health plans, and members may make referrals to case management.

2. The referral is made to the Santé case manager who is a licensed staff member and is educated, trained, and experienced in the case management process.

3. The case manager functions within the scope of his/her practice.

4. The referral source provides the case manager with demographic, healthcare, and social data about the member being referred.

5. The case manager obtains eligibility information on the member and notifies the referral source of the member's eligibility status for involvement in the case management program.

6. If the member does not appear to be eligible, the case manager guides the referral source to an alternate method for managing the member's care.

7. If the member is eligible, the case manager continues to work with the referral source to obtain necessary information for implementing the case management process.

8. The case manager gathers the appropriate information to complete a case assessment for the member. The initial assessment is completed within 30 days from the date member is determined eligible for case management of member's health status, including condition-specific issues.

9. The case manager obtains consent for Ambulatory Case Management by sending a consent form via mail, or by documenting verbal consent of the member during the first telephone contact. The member is informed that participation in the program is not mandatory.

10. The case management assessment includes an evaluation of member-related clinical, psychosocial, and socioeconomic factors such as:
    - Age
    - Health Status
    - Clinical history, including medications
    - Mental Health/Cognitive functioning
    - Co-Morbidities
    - Visual and hearing needs, preferences or limitations
    - Complications
    - Activities of daily living
    - Life Planning
    - Barriers to meeting goals
    - Home Environment, including care giver and cultural/language barriers
    - Progress of Treatment

    Approved criteria are applied and determination is made on a case by case basis.

11. Access to appropriate individual, Santé and community-based resources are reviewed.

12. To make appropriate Utilization decisions, Santé personnel may consider the characteristics of the local delivery system. These may include, but are not limited to:
    - Availability of SNF, sub-acute or home care services

- Coverage of benefits for SNF, sub-acute, or home care
- Ability of local hospitals to provide recommended services within the length of stay.

13. The case manager develops a plan of care that includes the following:
    - interdisciplinary action plan (team treatment plan),
    - a link to the appropriate institutional and community resources
    - Measurable short- and long-term goals.

14. The contracted providers and the member are responsible for implementing the plan of care. Upon written request, providers and members may request a copy of the clinical guidelines.

15. The case manager monitors the progress of the implemented plan of care.

16. The case manager serves as a resource throughout the implementation of the Plan and makes revisions in the plan as is appropriate.

17. The case manager also coordinates appropriate educational sessions and encourages members' role in self-help and adherence to treatment programs and medication regimes.

18. Progress toward the member's achievement of treatment plan goals is monitored in order to determine an appropriate time for the member's discharge from the case management program.

19. As each member's case is closed, they are asked for written feedback on their impression of their experience with the case management program. The feedback is collected and reviewed, and at the end of each year an evaluation is developed to measure the effectiveness of the program as well as areas that need improvement.

SANTÉ PHYSICIANS IPA

Policy/Procedure

BASIC CASE MANAGEMENT PROGRAM DESCRIPTION

Policy: 4.01a
Origination Date: 11/2023
Last Revision Date: 01/2024

Purpose:
The purpose of the Santé basic case management program is to ensure completion of HEDIS quality-of-care measures for members who are discharged from any inpatient hospital, skilled nursing facility or seen and released in an emergency room to ensure they are contacted by or seen by a Provider within a seven-day period.

This case management process provides timely education and assistance with access to care and services, with the goal of preventing unnecessary readmissions and ER visits.

Scope:
Case managers will complete transitions of care assessment. This will identify members for member engagement, on-going management and PCP collaboration. The case managers will work collaboratively with all members of the healthcare team, including discharge planners at the affiliated hospitals and case management staff at the contracted health plans. The Medical Director and Utilization Management Committee members will be involved in overseeing these case management functions.

Policy:
The Santé case management program will accomplish the following in order to complete the HEDIS Quality of Care measures:

Transitions of Care Measures (TOC)

- Notification of an inpatient admission and discharge is sent to the members PCP
- All inpatient admissions create a Clinical Alert in Quick Cap in-order to document evidence of patient engagement by Case Manager
- Follow-up after avoidable emergency department visits
- Ensure post discharge visits with PCP or Specialist where Medication Review and Reconciliation Post-Discharge (MRP) will be documented
- Verify home health services, DME, transportation and medication ordered have been received
- Ensure family/caregiver support is in place
- Identify ongoing coordination of care needs

Procedure:
The following is the criteria used to qualify a member for the Basic Case Management

- Members with an inpatient admission
- Members with multiple avoidable ER visits
- Clinical Alerts in Quick Cap based on Inpatient or ER CPT Code identified in an authorization or claim
- Clinical Alerts in Quick Cap based on specific chronic condition diagnoses
- Identification of qualifying condition during Health Risk Assessment
- AVA Patient Priority Work list
- Provider Referrals

Examples of Eligible chronic conditions

- COPD
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Major depression
- Heart failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

Acuity Level

High

- Multiple inpatient admissions or ER visits
- Multiple high risk chronic conditions
- Acuity Level Red on the AVA Daily Census
- Members with 10 or more open care gaps

Moderate

- Members with chronic ongoing needs
- Acuity Level Yellow on the AVA Daily Census

Low

- One inpatient admission
- Acuity Level Green on the AVA Daily Census

Initial Assessment

- Health Risk Assessment will be completed for each member as soon as possible, but no later than 30 calendar days from identifying member for Basic Case Management.
- If applicable, condition specific assessments are completed (example: Diabetes, Cardiac Care)
- Health Education Materials will be mailed to the member as needed

Individual Care Plan is completed

- Define patient goals
- List barriers to patient's goals
- Identify symptoms
- List interventions
- Document support the patient is receiving
- Identify patient's allergies and medications
- Note expected outcomes from treatment

Interdisciplinary Care Team (ICT) Meeting

- Case Manager may meet with member and PCP as needed to discuss patients care to complete goals

INPATIENT CONCURRENT REVIEW

- Authorization is created and admission letter is sent to the facility and PCP
- Case Manager reviews concurrently to ensure patient meets level of care submitted
- Case Manager uses CMS and InterQual criteria to determine medical necessity and send charts for denial if the inpatient hospital level of care submitted is not met
- Case Manager reviews criteria to ensure members meet SNF or Acute Rehab level of care before authorizing a discharge to a lower level of care
- Case Manager provides authorization for DME and Home Health ordered at discharge from an inpatient facility.
- Case Manager uses CMS and InterQual criteria to ensure medical necessity is met for SNF and Acute Rehab admissions and send charts for denial if the level of care is not met

TRANSITIONS OF CARE

- Inpatient authorization will prompt a Clinical Alert in Quick Cap
- Once the patient discharges from an inpatient setting a post discharge call is made and documented in the Clinical Alerts module
- Case Manager ensures all home care needs are addressed appropriately
- The Health Risk Assessment form is filled out
- Based on the member's needs, the clinical alert is either closed or pended for future follow up
- If member qualifies for complex case management, a referral to the health plan's complex case management department is completed using their referral form

SANTÉ PHYSICIANS IPA

Policy/Procedure

CASE MANAGEMENT CONDITIONS

Policy: 4.02
Origination Date: 7/1995
Last Revision Date: 01/2024

Purpose:
Certain conditions make a member eligible for the Santé case management program. Each contracted health plan also may have specific lists of conditions which are used by the health plan staff to enter the member into the health plan's own case management program. The Santé Physicians IPA and health plan case management staff work collaboratively to manage the members' care.

Scope:
The Utilization Management Committee is involved in developing and administering an effective case management program according to Santé approved guidelines.

The Utilization Management Committee may develop or approve established lists of the conditions that make a member eligible for the case management program. Certain conditions have been recognized nationally by both providers and payers as being requisite for case management services. A list of these conditions may include but is not limited to the following:

1. Ongoing needs to maintain optimal health status
    a. Chronic conditions
        - Asthma
        - Diabetes
        - Cardiovascular Disease
        - Migraines/Headaches
    b. Multiple hospital admissions
    c. Multiple emergency department visits

SANTÉ PHYSICIANS IPA

Policy/Procedure

TRANSPLANT CASE MANAGEMENT

Policy: 4.03
Origination Date: 2/2000
Last Revision Date: 01/2024

Purpose:
Certain diagnostic conditions make a member eligible for the Santé Transplant Case Management. Each contracted health plan also may have specific lists of conditions which are used by the health plan staff to enter the member into the health plan's own case management program. The Santé Physicians IPA and health plan case management staff work collaboratively to manage the care of the Transplant candidate.

Procedure:
Santé notifies the Health Plan in advance of all potential transplant cases. Requests for organ transplants with supporting documentation are immediately forwarded to the Health Plan. In emergency situations the health plan is notified within 24 hours of receipt notification of admission.

* A report of authorizations is generated and submitted to appropriate health plan on a monthly basis.

See monthly Transplant Log.

SANTÉ PHYSICIANS IPA

Policy/Procedure

HEALTH RISK ASSESSMENT

Policy: 4.04
Origination Date: 8/1999
Last Review Date: 01/2024

Purpose:
To ensure the identification of potential high-risk NEW medical members requiring case management.

Policy:
Santé will review all information received related to Health Risk Assessment (HRA) surveys on all newly enrolled senior members in order to identify potential high risk members requiring case management services. Santé will provide the case manager with information regarding the senior members' functional status and living arrangement for care plan development, establishing linkages between risk identification and case management. This survey information is obtaining from the contracted health plan.

Procedure:
- Survey information will be supplied on all new senior members
- The survey provides identification of members who qualify for 'institutional" status or with COB issues, (i.e. ESRD) and are appropriate candidates for Disease management / Case management.
- Contact with members will be conducted by the Utilization management department/ Case Managers telephonically.
- Survey answers will be assessed and statistically scored to predict certain disease, medical and psychosocial issues. They will identify risk factors such as age, gender, self reported health status, self reported chronic illnesses (i.e., Coronary, Diabetes Mellitus), functional status, psychosocial functioning and support and prior service use (i.e., hospital stays, physician visits, ER visits).
- Case management will be initiated on all high-risk seniors, and high-risk notification will be initiated to the member's PCP.
- Case Management will notify the contracted health plans Case Management Department of all high risk seniors, coordinate case management efforts and cooperate with the health plan audits of the members' medical record and claims. (Santé does not report on pharmacy utilization).

SANTÉ PHYSICIANS IPA

Policy/Procedure

AMBULATORY AND INPATIENT CASE MANAGEMENT

Policy: 4.05
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
Case Management includes a combination of activities designed to focus on organizing and sequencing resources and identifying gaps within the community, caregiver, and provider systems. In addition, Case Managers coordinate medically necessary care and assist in arranging support and education for patients and caregivers.

Scope:
The management of the member's care includes experienced and effective handling of expected admissions, plans for eliminating unproductive inpatient occupancy, and providing equal or better care at an appropriate level of care. The member's health plan benefits will be maximized by the UM staff in coordination with the health plan staff in order to provide the most appropriate, cost-effective care.

Policy:
The UM case management staff will assist in the financial and medical management and monitoring of the ambulatory and inpatient care of members with complex diagnoses and/or multi-system diseases. The UM case management staff will identify and utilize resources that reduce the risk for readmission if the member is hospitalized. Processes are implemented with the goal of effective management of the case by the use of assertive discharge planning, and close outpatient monitoring by the primary care and specialty care providers. All services for ongoing ambulatory care that requires prior authorization will follow the Santé process and time frames for authorization requests. (Refer to Policy 2.11 Authorization/ Referral process.)

Procedure:

The following is the procedure of ambulatory/inpatient case management:

1. Adequate clinical and administrative data is acquired for determining the assignment of appropriate services.

   Sources used for the accumulation of data may be:
   a. Hospital admission records
   b. Eligibility/Benefits information

c. Provider referrals
d. Member utilization records
e. Outpatient clinical records
f. Interdisciplinary team conferences
g. Management team conferences (including health plan staff)

2. Resources are utilized by the case management staff to ensure the effective management of complicated and costly cases.
   a. Cost effective healthcare services are identified, coordinated, implemented and evaluated on an ongoing basis.
   b. The long-term process is coordinated by the effective utilization of appropriate clinical, individual, and environmental resources such as:
      i Synthesizing primary care and specialty provider input.
      ii Utilizing applicable clinical pathways.
      iii Interpreting benefits and assigning appropriate services.
      iv. Attending to the individual member's physical and psychosocial characteristics and needs.
      v Applying knowledge and information gained from case studies and research.
      vi Following up with the member to ensure compliance with their treatment plan.

3. In the event that the member is hospitalized, effective methods will be applied which respond to the early management of medically necessary care required after discharge.

4. Discharge planning will be provided in a timely and cost-effective manner.
   (Refer to Policy 4.07 Case Management Discharge Planning).

5. Identification of members readiness to be discharged from case management oversight shall be determined by the Case Manager and medical management staff by evaluation of case specific criteria, i.e., expiration of member eligibility, transition to a different PMG, exhaustion of benefit coverage, clinical status no longer requiring case management oversight, etc.

SANTÉ PHYSICIANS IPA

Policy/Procedure

DISEASE STATE MANAGEMENT

Policy: 4.06
Origination Date: 12/1999
Last Review Date: 01/2024

Purpose:
Identify and select focused chronic areas for improvement and preventive health resource allocation. To facilitate and monitor the chronic disease state members use of an array of health and social services to ensure increased quality of life, member satisfaction, compliance with medical care regimen, member self determination, continuity and quality of care, and cost containment.

Policy:
Santé Physicians will conduct disease state management on all identified chronic disease state members. Appropriateness criteria will be limited to situations where the clinical benefit to the member would be reasonably enhanced vs. existing patterns of care.

Procedure:
- Santé will conduct member population surveys, encounter data surveys, and claims surveys at least annually, to identify chronic conditions for the purpose of conducting disease state management. Early assessment will ensure that services are generated in a time and cost effective manner.
- Santé will assess the frequency of certain disease states, procedures, and age/gender specific demographics in order to create a single list of highly recurring outlier areas for intervention. Santé will create priorities for clinical intervention. Interventions may be member or practitioner directed.
- High Risk members (i.e., patients with history of inpatient or emergency utilization within a previous 12 month period for the identified condition) will be referred for intensive case management or one-on one educational intervention. Moderate and low risk members will be referred to appropriate interventions (i.e. wellness programs, educational programs, and distributions of videos, literature and / or diagnostics aids).
- Disease State Management referrals may also be made by Santé Case management department.
- The Disease State Management (DSM) program will reflect linkages with Sante UMC, QMC, and case management program, preventive health programs and practice guidelines.
- DSM programs will be provided in language appropriate to the member population.
- Prior to DSM implementation all proposed DSM programs will be reviewed and approved the UMC and all applicable PCP's. DSM program implementation will

allow for PCP and member participation declination, as will as eligible member self-referral.

- Applicable PCP's and members will be notified of the program goals and inclusion criteria.
- Santé will designate a qualified healthcare professional to conduct disease state management. This designee will operate in conjunction with Santé UMC and UM department
- Disease state management may include providing to identify members' videos, literature, diagnostic aids and other support to aid the members' practitioner in-patient care management.
- A disease state management file will be implemented for all members identified for DSM.
- Outcomes/health status will be measured by Santé, who will identify/establish measurable disease state management goals, compare the client's disease course to an established critical pathway to determine variances and establish quantifiable impact. Outcome measurement will be reported to the UMC.

SANTÉ PHYSICIANS IPA

Policy/Procedure

CASE MANAGEMENT
DISCHARGE PLANNING

Policy: 4.07
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
The UM Committee recognizes that the management of efficient discharge planning by case management staff is one of the most critical functions related to hospital utilization. Effective discharge planning is an important activity related to cost savings and member satisfaction.

Scope:
The case management staff works with the attending physician who is ultimately responsible for overseeing the planning and discharge of the member from the hospital.

Policy:
The case management staff (qualified and appropriately licensed Health Professionals) will conduct a comprehensive discharge planning process for hospitalized members according to Santé approved case management policies and procedures. The discharge planning process will be evaluated updated and approved annually as part of the case management program. .

Procedure:
This following is the case management discharge planning procedure.

1. Member needs are anticipated upon admission and documented for the hospital discharge planner/case manager. Relevant clinical information is obtained and the treating physician is consulted as appropriate.

2. Required needs are attended to when the member enters the hospital.

3. Upon admission, the member's care plan will be developed to include a planned discharge and the level at which aftercare would be received. UM criteria will be applied appropriately and consistently.

4. Special services and follow-up provider office visits are arranged as needed.

5. Home healthcare and hospice referrals are made (as appropriate).

6. Special planning and attention is given to the discharge planning function of transferring patients from the hospital to a SNF.

7. Special needs are considered for members without family or significant others, and those who are frail upon referral.

8. Special needs are considered for members who have
   Joint replacement surgery
   Organ transplant surgery
   Cardiac Surgery
   Ostomy surgery
   Neurosurgery
   Infusion therapy (TPN, chemotherapy, anticoagulants)

9. Arrangements are made for members with communication barriers as needed (e.g., disabled, language barriers).

10. Upon referral, special needs are considered for members (e.g., members who live alone, come from special living facilities, require special monitoring, or require long term support such as tubes, catheters, diabetic care, and wound care).

11. The discharge plan is made in advance of discharge and it recognizes the member's needs based on the following:
    a. Social environment of the member
    b. Members support structure through family & friends
    c. Education & training regarding the member's condition
    d. Availability and accessibility of needed services.
    e. General safety of the member
    f. Complete care of the member on a continuum.

SANTÉ PHYSICIANS IPA

Policy/Procedure

OUT-OF-PLAN MEMBER MONITORING

Policy: 4.08
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
Out-of-plan services are managed by the case management staff in order to bring the member back into the care of contracted providers and facilities as soon as it is appropriate.

Policy:
The case management staff will manage and track out-of-plan emergency room visits and hospitalizations for members and arrange for transfer to an in-plan hospital or provider as soon as the member is stable for transfer. According to contract terms, the case management staff also will work with the health plan staff.

Procedure:
The following is the procedure used for managing member out-of-plan services:

1. The case management staff gathers the following information for out-of-plan member emergency room visits and hospitalizations:

    a. Member name
    b. Member ID #
    c. Out-of-network facility name, location and telephone number
    d. Contact person/case manager
    e. Date of ER visit or hospitalization
    f. Member's diagnosis
    g. Services provided
    h. Member's clinical status
    i. Attending physician's name and telephone number
    j. Member's primary care physician

2. The case management staff refers out-of-plan hospitalization of a member at a non-contracted facility (which is within the contract geographic region), to the member's primary care physician.

a. The Primary Care Physician/Case Manager arranges for the member to be transferred to a contracted facility as soon as he/she is stable for transfer.
b. The utilization management staff must be notified as soon as possible by the hospital staff (of the out-of-plan hospitalization) so that they can closely manage the authorization of services and facilitate transfer to an in-plan hospital.

3. For members who are hospitalized outside of the contract geographic region (specified radius), the health plan staff assist the case management staff in managing the member's care and in facilitating transfer to a contracted facility.

a. Authorization of services is not a function of the case management staff.
b. Both the case management staff and the health plan staff should be notified of out-of-area emergency room visits and hospitalizations.
c. The member's primary care physician will determine with the out-of-area attending physician when it is appropriate for the member to be transferred safely back in to the area to a contracted facility.
d. The case manager will ascertain that there are no benefit limitations.

SANTÉ PHYSICIANS IPA

Policy/Procedure

CASE MANAGEMENT OF SKILLED NURSING FACILITY (SNF) PLACEMENT

Policy: 4.09
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
The Case Management staffs are involved in the placement of members into skilled nursing facilities when daily skilled nursing or rehabilitation services cannot be provided in environments of lower levels of care.

Scope:
The Case Management staff assists in the evaluation and placement of members into skilled nursing facilities. Appropriate SNF placement involves several factors that include:

The member requires skilled nursing services or skilled rehabilitation services on a daily basis and these services (from an economic and practical standpoint) only can be provided in a SNF.

Policy:

1. The Case Management staff will assist in the placement of members into skilled nursing facilities based on the member's eligibility and schedule of benefits.

2. In the process of working with the healthcare team, particularly the Primary Care Physician, hospital discharge planners and health plan staff, the case management staff will encourage the appropriate transfer of patients to a lower level of care at an early point in their hospitalization.

3. Contracted skilled nursing facilities will be utilized in this process.

4. When it is determined that the member should be maintained at the facility in a "custodial" status or should be transferred to a board and care or home environment, the Case Management staff will facilitate such transactions.

Procedure:
The following is the procedure followed by the case management staff for assigning and monitoring appropriate SNF placement.

1. The member's eligibility and schedule of benefits are checked in order that appropriate services will be authorized.

2. The Case Management staff gathers adequate information for determining the appropriate level of care including:
    a. The member's level of functioning and independence.
    b. Whether skilled care is required to achieve the member's optimal health status.
    c. If skilled care is required, if around-the-clock care or observation is medically necessary.
    d. The realistic potential (and the time line) by which the member will regain some functional independence.
    e. Expected outcome of the member's health status without SNF placement.
    f. Whether other alternatives of care for the member would be sufficient to achieve treatment goals, such as:
        i Home Healthcare
        ii Custodial Care
        iii Adult or Child Day Care
        iv Family Education and Training
        v Community Networks and Resources

3. The Case Management staff evaluates the situation and may determine that SNF services are reasonable and necessary for the appropriate treatment of the member's illness, condition, or injury.

4. Once the determination is made regarding the need for SNF placement, an order (authorization request) is obtained from the physician.

5. The Case Management staff is involved in the development, management, and monitoring of the member's treatment plan.

6. The treatment plan is implemented, evaluated, and revised by the team of providers and staff including the case management staff, physicians, the SNF providers and staff, and the health plan staff. The member and family also are involved in this treatment plan implementation process. Case Management staff will perform concurrent review for medical necessity at least weekly on SNF patients, or more frequently as circumstances dictate.

7. The Case Management staff together with the interdisciplinary team of providers and staff, guide the member toward meeting the treatment plan goals which include transfer to a lower level of care when it is appropriate.

8. The Case Management staff assists in the discharge planning process and the transfer and follow-up of the member at the next level of care.

SANTÉ PHYSICIANS IPA

Policy/Procedure

CASE MANAGEMENT OF HOME HEALTH & HOSPICE SERVICES

Policy: 4.10
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
Case Management staff assist in the management of the member's care in the home environment in order to promote the delivery of cost-effective healthcare services by reducing periods of hospitalization and facility placement, and by preventing unnecessary admissions and re-admissions to these institutions.

Scope:
Home healthcare and hospice services are implemented in order to achieve the following objectives:

1. Meet the member's healthcare needs at home by utilizing contracted providers who provide comprehensive skilled and support services.

2. Assist in the interdisciplinary team management and provision of the member's care in the most appropriate setting.

3. Provide services that maximize the member's potential to achieve an optimal state of health, ability to function, and comfort while residing in the home environment.

4. Assist in the networking and referral to appropriate community support services to encourage functional independence and to provide support systems.

5. Promote cost-effective healthcare services by reducing the need for hospitalization or facility placement.

Note: Hospice services also include the provision of palliative care and support services which focus on the member and family physical, psychosocial, and spiritual needs.

Policy:

- Case Management staff will evaluate a member's illness, injury, degree of disability, and medical needs for appropriate referral to home health or hospice services and check the member's eligibility and schedule of benefits.
- The Case Management staff will base their evaluation for home health or hospice service referrals on Santé and health plan approved guidelines
- A member is determined to be 'terminally ill' when the member's prognosis indicates a life expectancy of one year or less.

Procedure:

The following is the procedure followed in the management of home health and hospice cases:

1. Case Management staff will identify members who would benefit from home health or hospice services.

2. The member's eligibility and benefits are checked and only appropriate services will be authorized.

3. Utilizing Santé Physicians IPA and health plan approved guidelines, the determination will be made as to the appropriateness of the referral to Medicare certified providers of home health or hospice services.

4. The Case Management staff will coordinate the referral to home health or hospice services with the primary care physician and obtain a signed physician's order that indicates the type and length of service required.

5. The services will be authorized according to Santé policy and procedure.

6. The Case Management staff will arrange for contracted providers to carry out the treatment plan which involves skilled nursing, therapeutic services, and support services as appropriate.

7. The Case Management staff will be involved in the management of the member's treatment plan and will communicate progress and actions to the health plan staff.

8. Hospice services are authorized for certification periods. A certification period consists of two 90-day periods and an unlimited number of 60-day periods. (AB892,1999)

9. Covered Hospice services are available on a 24 hour basis to meet the needs of the member's care and to manage the terminal illness and any related conditions.

10. The Case Management staff (as it is necessary) also will manage the member's discharge from service and follow-up care.

11. The Case Management staff will document all actions regarding the management of the home health or hospice services appropriately.

SANTÉ PHYSICIANS IPA

Policy/Procedure

DURABLE MEDICAL EQUIPMENT (DME)

Policy: 4.11
Origination Date: 7/1995
Last Review Date: 01/2024

Purpose:
The Case Management staff assists in the process of justifying and authorizing (when indicated) the assignment of durable medical equipment to members for the purpose of providing comprehensive healthcare services.

Policy:
The Case Management/UM Coordinators will authorize and monitor the necessity and appropriateness of DME and supply usage by members according to the member's eligibility and benefits and existing Utilization Management policy.

Contracted providers will supply the durable medical equipment to the members (except in rare circumstances).

Scope:
This policy and procedure for durable Medical Equipment also applies to corrective appliances, prosthetics, and associated medical supplies and equipment.

Procedure:
The following is the procedure followed by the case management staff for authorizing and monitoring DME and medical supply usage:

1. The member's need for home medical equipment and the case management staff identifies medical supplies.

2. The member's eligibility and schedule of benefits are checked, and all authorizations are made accordingly.

3. Santé and health plan guidelines are applied to determine if the criteria are met for the appropriate assignment of the equipment and supplies.

4. Alternative methods for providing effective, high quality and more cost efficient services are explored and pursued as appropriate.

5. The member's need for the home equipment or supplies is evaluated according to diagnosis, prognosis, reason that the equipment or supplies are needed, and the length of time of the need, and the plan for home treatment.

6. If it is determined that the member does need the DME or supplies, the referral/ authorization process is followed according to Santé Physicians IPA policy and procedure (see Utilization Management Referral/Authorization Process).

7. Authorizations typically are made on a short-term basis (specified in number of weeks).

8. Long-term authorizations typically are made for one month at a time. The case management staff conducts monthly assessments of the members' eligibility and benefits and of the cost of the equipment (to ensure that rental cost does not exceed purchase price). This process will be coordinated with the health plan staff.

The member's need for DME or supplies is monitored, and the case management staff ensures that services are discontinued as soon as it is appropriate.

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

Policy: 5.01
Origination Date: 12/2015
Last Review Date: 01/2024

Purpose:
Santé Physicians IPA will cooperate and comply with the Comprehensive Perinatal Services Program (CPSP). CPSP is a state funded program run by the California Department of Public Health that provides services (initial assessment with evaluation of risk factors, standard obstetric, nutrition, psychosocial, health education, referrals, as needed, and postpartum assessment) to all pregnant women from conception to 60 calendar days postpartum.

Policy:
Santé Physicians IPA will follow State Department of Health Services (DHCS) Agreement 04-36069 Exhibit A, Attachment 10 Pregnant Women [MMCD APL 12-001]

Procedure:

- All Santé Physicians IPA practitioners 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;
    - initial assessment with evaluation of risk factors
    - nutritional services
    - health education
    - psychosocial services
    - referrals, as needed
    - 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 is retained in the woman's file/chart
- Monitoring process to ensure appropriate utilization of CPSP services

Process for practitioners/providers to obtain current CPSP tools and guidelines

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

Process – Evidence includes:

- Identification, referral, and coordination of care for CPSP eligible enrollees will be the role and responsibility of identified staff within practitioners office to include:
    - Identify pregnant women and offer CPSP services
        - Examples:
        - *Pregnancy referral logs*
        - *Claims sweeps*
        - *Case Management logs*
        - *Authorization specialty referral logs*
    - Identify high risk pregnancies and refers to perinatology and genetic screening.
        - Examples:
        - *Claims sweeps*
        - *Case Management logs*
        - *Authorization specialty referral logs*

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

CHILD HEALTH and DISABILITY PREVENTION PROGRAM (CHDP)

Policy: 5.02
Origination Date: 12/2015
Last Review Date: 01/2024

Purpose:
Santé Physicians IPA will cooperate and comply with the 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.

Policy:
Santé Physicians IPA will follow State Department of Health Services (DHCS) Agreement 04-36069 Exhibit A, Attachment 10 LA Care Contract

Procedure:
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 are provided in accordance with the most current CHDP standards
- Ensures that performance of the CHDP age appropriate assessment is 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)
- Requirement that practitioners follow AAP periodicity tables. This schedule requires more frequent visits than does the periodicity schedule of the CHDP schedule.
- 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

- Method for monitoring and improving utilization of CHDP services including follow up to ensure services are provided

Process – Evidence includes:

- Current list of CHDP certified practitioners and providers
- CHDP education to new hires, providers and staff, inclusive of how to access a CHDP paneled practitioners, CHDP Standards and updates, at least annually
- Monitoring and intervention process to ensure appropriate utilization of CHDP standards
  - Examples of monitoring compliance may include:
    - *Medical chart audits*
    - *encounter data reports specific to CHDP codes*
    - *PM 160 report form*
    - *Feedback to PCPs (faxes/letters) resulting from monitoring findings*
    - *claims report specific to CHDP codes (applicable to POs delegated for CHDP payment)*

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

FAMILY PLANNING SERVICES

Policy: 5.03
Origination Date: 12/2015
Last Review Date: 01/2024

Purpose:
Santé Physicians IPA allows members to access any qualified family planning practitioner/provider in-network or out-of-network

Policy:
Santé Physicians IPA will follow State Department of Health Services (DHCS) Agreement No. 04-36069, Exhibit A, Attachment 5, Utilization Management 2, Pre-authorization and Review Procedures

Procedure:
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

APL 18-019 November 21, 2018

Pursuant to state law, MCPs must cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a provider or pharmacist or at a location licensed or authorized to dispense drugs or supplies. This means MCPs must reimburse for 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.

The Medi-Cal Provider Manual specifies appropriate 12-month supply quantities of these self-administered hormonal contraceptives for continuous cycle users.

A physician, physician assistant, certified nurse midwife, nurse practitioner, and pharmacist are all authorized to dispense medication. When furnished by a pharmacist, self-administered hormonal contraceptives must be dispensed in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. A registered nurse who has completed required training pursuant to BPC *Section 2725.2(b)* may also dispense contraceptives when Evaluation and Management procedure 99201, 99211, or 99212 is performed and billed with modifier 'TD.'

Absent clinical contraindications, MCPs 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. In addition, MCPs must not impose utilization controls that are more restrictive than those described in the Medi-Cal Provider Manual.

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

STERILIZATION CONSENT PM330

Policy: 5.04
Origination Date: 12/2015
Last Review Date: 01/2024

Purpose:
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.

Policy:
Santé Physicians IPA will follow [CCR-Title 22, 51305.1-51305.4 42 C.F.R. Sections 50.201-50.210 and Section 1396][DHCS State Contract]

Procedure:

- 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.
- Correct PM 330 Form 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 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 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

- 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*

Monitoring and intervention process to ensure sterilization requirements are implemented.

- ***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*

Process – Evidence includes:

Monitoring and intervention process to ensure appropriate utilization of Sterilization standards.

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

CARVED OUT SERVICES

Policy: 5.05
Origination Date: 12/2015
Last Review Date: 01/2024

Purpose:
Santé Physicians IPA will 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

Policy:
Coordination and collaboration of the member's care is documented between PCP and referred service. Education to all new hires within 90 days, providers, and staff, and annual updates as indicated for the below CA programs.

Procedure:

- The medical record reflects 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 reflects coordination of specialist services with the Health Plan network.
- The medical record reflects those members with developmental disabilities, eligible for Home and Community-Based Services (HCBS) Waiver have been referred.
- The medical record reflects the member receiving 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, other than kidney, (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.

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

CASE MANAGEMENT / COMPLEX CASE MANAGEMENT PROGRAM DESCRIPTION

Policy: 5.06
Origination Date: 12/2015
Last Review Date: 01/2024

Case Management

Purpose:

The purpose of the case management program is to ensure that medically necessary care is delivered in the most cost-efficient setting for members who require extensive or ongoing services. The program will be focused on the delivery of cost-effective, appropriate healthcare services for members with chronic care needs.

Proactive clinical and administrative processes are implemented to identify, coordinate, and evaluate appropriate high quality services which may be delivered on an ongoing basis.

This case management process is directed at coordinating resources and creating appropriate cost-effective alternatives for catastrophically, chronically ill, or injured members on a case by case basis to facilitate the achievement of realistic treatment goals.

Scope:

Case managers will coordinate individual services for members whose needs include ongoing medical care, home health and hospice care, rehabilitation services, and preventive services. The case managers will work collaboratively with all members of the healthcare team, including discharge planners at the affiliated hospitals and case management staff at the contracted health plan offices. The Medical Director and Utilization Management Committee members will be involved in overseeing these case management functions.

Complex Case Management

Santé Physicians IPA refers all Complex Case Management Cases to Anthem Blue Cross Medicaid Case Management Department within 2 business days of identification. Direct all Case Management cases to Anthem's Care Management Unit at phone number at 1-888-334-0870 or fax 1-866-333-4827.

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

INITIAL HEALTH APPOINTMENT (IHA)

Policy: 5.07
Origination Date: 12/2015
Last Review Date: 01/2024

Purpose:
The purpose of these assessments is to determine the health education needs of the patients based on the patient's lifestyle, behavior, environment, cultural and linguistic needs. It includes a comprehensive history and physical assessment, health education needs including, immunizations, dental, nutrition, physical activity, pregnancy prevention, psychosocial adjustment, safety, sexually transmitted diseases, HIV prevention, tobacco, violence prevention, ETOH, drug use and F/U as needed.

DHCS increased the number of IHA pediatric questionnaires from four (0–3 years, 4–8 years, 9–11 years, and 12–17 years) to seven (0–6 months, 7–12 months, 1–2 years, 3–4 years, 5–8 years, 9–11 years, and 12–17 years). In addition to the single questionnaire for adults, DHCS created a second questionnaire to address the unique needs of seniors and Persons with Disabilities (SPDs). (IHA associated education materials include):

- Staying Healthy California Tip Sheets – created as a collaborative effort between Medi-Cal and Health Plans with assistance from the California Department of Health Care Services (DHCS) and also available in the 7 mandated threshold languages.
- Staying Healthy Assessment Counseling and Resource Guide – created as a collaborative effort between the OCPM and 15 CDHS public health programs as a guide to assist health care practitioners in use of the SHAT.

The "IHA" and associated education material for all ages and in all mandated threshold languages may be obtained from the DHCS Website
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

Policy:
IHA– Santé Physicians IPA is accountable for ensuring that members have an IHA within the required timeframes. [State Contract Agreement No.10-87049, Exhibit A, Attachment 10, 11 Title 22, CCR, Section 53851 (b)(1);[MMCD Policy Letters PL08-003, 13-001 and 07015] [California Health & Safety Code, Section 1367.66][MMCD APL14-4004]

Procedure:

All Members:

- Members age 18 months and older have an IHA within 90 calendar days of enrollment. The IHA must be conducted in a culturally and linguistically appropriate manner for all patients, including those with disabilities.
- Members under 18 months have an IHA within 90 calendar days of enrollment. The IHA must be conducted in a culturally and linguistically appropriate manner for all patients, including those with disabilities.
- Members have the IHA and periodically and within 90 days of their enrollment.
- Diagnostic, treatment and follow-up services for symptomatic findings or risk factors identified in the IHA within 60 days following discovery
- TB screening, diagnosis, treatment, follow up and coordination of care for all members
- Providers identify (initially and annually) all members (of any age) who use tobacco products, provide referral to smoke cessation counseling and document in the member's medical record[MMDC APL14-006]
- Initial & annual assessment and documentation of tobacco use for each adolescent and adult member;
- FDA approved tobacco cessation medications (for non-pregnant adults of any age);
- Individual, group and telephone counseling for members of any age who use tobacco products;
- Referral to CA Smokers Helpline or other comparable Helpline Services;
- Services for pregnant tobacco users;
- Prevention of tobacco use in children and adolescents;
- Provider resources (including websites); implementation of a system to identify tobacco users.
- An overview of the Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008.
- Special requirements for providing services for pregnant tobacco users.
- Available online courses in tobacco cessation
- Alcohol screening (SBIRT) of members **18 years and older** who answer "yes" to the alcohol question as part of routine care. [MMCD APL14-004]
- Providers utilize an expanded, validated DHCS recommended alcohol screening questionnaire when the member answered "yes" to the alcohol screening question. PCP offers the member an expanded, validated alcohol screening questionnaire. While any validated screening tool is acceptable, DHCS recommends the use of the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test—Consumption (AUDIT-C)".
- Providers do a follow up in 14 days after a positive screening
- Providers offer brief interventions (up to three 15-minute sessions) when appropriate.
- Any member identified with possible alcohol use disorders or at any time the PCP identifies a potential alcohol misuse problem, should be referred to the alcohol and drug program for evaluation and treatment.

Information about Alcohol Misuse Screening and Counseling (AMSC) services can be found on the following DHCS website:
http://www.dhcs.ca.gov/Pages/default.aspx

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Pediatric Members (ages 0-21yrs):

- Have an age appropriate IHA according to the most recent edition of the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP) for the Centers for Disease Control and Prevention (CDC) age specific guidelines and periodicity schedule. The IHA must also include an age specific assessment and services required by the Child Health and Disability Prevention Program (CHDP)
- Immunization services will not be subject to prior authorization.
- Developmental surveillance occurs during every periodic pediatric health visit.
- Developmental screening is done using standardized developmental screening tools during the periodic pediatric health visits at 9 months, 18 months, and 30 months.
- Have a dental screening/oral assessment and dental referral starting at age 3 or earlier, if warranted
- Documented lab testing for anemia, diabetes and/or urinary tract infection
- Includes identification, treatment and follow-up on obese members
- Network providers will document each member's need for ACIP recommended immunization as part of all regular health visits.
- The organization ensures that member specific immunization information is periodically reported to California Immunization registry (CAIR) Reports shall be made following the member's initial health appointment and all other health care visits which result in an immunization being provided. Reporting should be in accordance with all applicable and State Federal Programs.
- Quality department pulls IHA data from health plan portal.
- Quality to notify pediatric provider of identified child members requiring a blood lead screening to be completed
- Quality to notify (oral or written) parent/guardian of each child member identified of the blood lead testing requirements.
- Includes documented testing for lead poisoning in IHA, if appropriate. (Lead level checks at ages 12, 24, or 72 months) Lead level range-above 15 ug/dL should be referred to Los Angeles Lead Program
- Follow-up lead re-check done on lead levels 10 ug/dL to 14 ug/dL in 3 months
- Follow-up lead confirmatory (venous) re-check is performed on level levels 15 ug/dL to 19 ug/dL within 1-2 months
- Quality department to identify all child members under the age of six years old who have no record of a blood lead screening, including the age at which the screening was missed
- Includes documented testing for Sickle Cell (SCA) trait in the IHA (if appropriate)

Adult Members:

- For Asymptomatic Adults completion of an age appropriate IHA according to the most current edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) as documented by a history & physical & review of organ systems
- Includes immunizations for adults as required

Female Members:

- Includes a documented breast examination over the age of 40 years of age
- Includes a documented Mammogram at age 40 and over

- Includes documented Chlamydia screen for all sexually active females through 26. (high risk, e.g., new or multiple sex partners, prior history of STD, not using condoms consistently & correctly)
- Includes a documented cervical screening test for all sexually active women
- HPV immunization was offered to age appropriate females (9-26)

Identification of members without an IHA:

- Santé Physicians IPA utilizes a system to identify members without an IHA
- Santé Physicians IPA conducts outreach efforts to facilitate member compliance with IHA participation
- If IHA has not been completed, the medical record reflects attempts to schedule IHA
- If the IHA has not been completed due to missed appointments, the medical record reflects documented missed appointments and attempts for follow-up, as appropriate
- When a member has not made an appointment for an IHA, there must a process to ensure reasonable attempts to contact a member and schedule an IHA. All attempts must be documented**.**
- Outreach process to facilitate member compliance with IHA participation including:
    - At least two attempts, in addition to the initial outreach, are made to contact a member to schedule an IHA
    - Initial outreach may include new member enrollment package given at time of enrollment, IHA reminder messages, member newsletters and member Website or phone calls.
- Policy describes monitoring and intervention process to ensure appropriate utilization of IHA standards

IHA Process – Evidence includes:
The associated education material for all ages and in all mandated threshold languages may be obtained from the DHCS Website
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

- Instructions on how to use the IHA
- Member's refusal to complete the IHA must be documented
- IHA specific information and resources for providing culturally and linguistically appropriate patient health education services/interventions
- IHA clinical documentation requirements IHA timelines for administration and review
- Specific information regarding IHA resources and referral
- Monitoring process to ensure appropriate utilization of IHA standards

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

NEW TECHNOLOGY AND PROCEDURES

Policy: 5.08
Origination Date: 12/2015
Last Review Date: 01/2024

Policy:
The individual HMO Corporate Medical Department provides information related to the review of new technologies and procedures to Santé Physicians IPA.

This information is available to the Medical Director/Physician Advisors when a request is received for authorization of any new, non-traditional therapies or procedures.

All requests for services classified as Experimental/Investigational will be referred to the Health Plan for medical review and determination within 24 hours of initial receipt of request. Santé Physicians IPA denial notifications will adhere to established timeframes for urgent (2 days), concurrent (1 day) and retrospective (5 days). Denial letters will include instructions for referral to Health Plan for medical review and determination.

Decision-making and member notification is done by the Health Plan.

Members receiving denials of experimental/investigational treatment when terminally ill (defined as death before 24 months) or with a life threatening condition (defined as diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or disease or conditions potentially fatal outcomes where the end point of clinical intervention is survival) or seriously debilitating condition (defined as diseases or conditions that cause major irreversible morbidity) may be entitled to an external review/appeal process.

Independent external review organizations may be contracted by the health plan for the review/appeal process.

Additionally, terminally ill members may request a conference (telephonic or in person) when experimental/investigational treatment services have been denied. The member must first have participated in the standard appeal process until resolution or 30 days have passed (3 days for expedited appeals). Santé Physicians IPA will participate in the conference as requested by the Health Plan and in accordance with AB 55 guidelines.

MEDICAID REQUESTS FOR EXPERIMENTAL OR INVESTIGATIONAL

Immediate referral of all Medicaid requests for experimental or investigational treatments, including clinical trials, to Anthem for initial determination, regardless of benefit exclusion [CA Health & Safety Code 1370.4]

- Standard requests within 24 hours of receipt of request by fax (877-234-3588) or phone (888-831-2246 Option 3).
- Expedited requests must be completed and faxed on the same day of member or physician request.
- If the request is related to transplants, the information must be sent directly to the Anthem Medicaid Care Management Unit fax 1-866-333-4827. For questions call 1-888-334-0870.
- No denial of services considered experimental or investigational will be issued by the Provider Organization.
- Informational letter to member and practitioner should be issued immediately when sending the experimental/investigational referral to Anthem.

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

UTILIZATION MANAGEMENT REFERRAL PROCESS

Policy: 5.09
Origination Date: 12/2015
Last Review Date: 01/2024

Purpose:
The Utilization Management Committee oversees the development and implementation of an effective referral process.

Scope:
All referrals for services will be processed according to Santé approved policies and procedures.

Policy:
The Utilization Management staff will follow Santé's approved process for reviewing and authorizing (or denying) requested services. The authorization/referral determination will reflect the appropriate application of Santé's approved practice guidelines.
Santé Physicians IPA providers are not restricted in advocating on behalf of a member or advising a member on medical care. This advocacy may include, but not be limited to, treatment options (without regard to plan coverage), risks, benefits and consequences of treatment or non-treatment, or a member's right to refuse medical treatment and to self-determination in treatment plans.

Procedure:
The Primary Care Physicians act as "managers" and are responsible for ensuring that their patients in need of medical care beyond their scope of practice are referred to appropriate specialist providers. Referral forms are to be used when directing patients to contracted providers for services. (See Contracting and Participating Providers for plan physician names).

GLOBAL CARE REFERRALS

A Primary Care Physician may refer to a specialist for "global" care, effective for six (6) months care (or as specified below) without limitation on number of visits allowed for ONLY the following types of care:

1. "Total OB Care", effective from the date of referral to the six-week post-partum check.
2. "Global Oncology", to a hematology/oncologist ONLY for ongoing chemotherapy for malignancy.
3. "Radiation Oncology", to a radiation oncologist for ongoing radiation treatment.

4 “Global Allergy”, to an allergist for ongoing allergy treatment.

In this case, the number of visits on the referral is left blank. If the Primary Care Physician wishes the number of visits to be limited, then the referral is completed as usual. The referral process is followed per protocol.

SELF REFERRALS /DIRECT ACCESS

A female member can obtain OB/GYN services without first contacting her PCP. If the member is pregnant, or has a gynecological complaint, she may go directly to an OB/GYN specialist who provides such services in her IPA. If such services are not available in the IPA, she may go to one of the IPA’s referral physicians.

Other direct access/self-referral specialties are defined by individual Health Plan Medical Policies. (Refer to Santé Physicians Administrative Manual, Section: UM, Self-referrals.)

STANDING REFERRALS

A member, who requires 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 health care [28 CCR 1300.74.15(f); CA Health & Safety Code 1374.15 (a)(b)] 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 specialized knowledge of HIV medicine, the Provider Group will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria. [CCR 1300.74(f); CA Health & Safety Code 1374.16] Determinations for such requests must be made within 2 business days of the date of receipt of all medically necessary information.

The PCP, specialist or PMG Medical Director determines individually or by consensus that continuing care from a specialist is appropriate care. Referrals are made based upon a designated treatment plan. The referral for care is to be made within 4 working day of the date of the proposed treatment plan.

The PCP must refer to an Out-of-Network specialist if one is not available within the PMG. Members with standing referrals will be considered candidates for Disease State Case Management and appropriate referrals will be made.

A ‘**standing referral’** must be processed whereby a member is referred by a PCP to a specialist for more than one visit without the PCP having to provide a specific referral for each visit. If appropriate, a treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized and require that the specialist provide the PCP with regular reports on the health care provided to the member. The referral process is followed per protocol. The approval may include the number of visits,

time period for which approval will be made, extension request process, and the reporting required from the SCP to the PCP and/or the IPA Medical Director.

Decisions and determinations regarding authorizing 'standing referrals' will be made in accordance with Standard UM timeframes.

SECOND OPINIONS

Requests by members for 'second opinions' will be processed and provided by a qualified PCP or specialist under certain conditions. These conditions may include:

- The member questions the reasonableness or necessity of a recommended surgical procedure.
- 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
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting tests results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment
- The member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- The authorization process must take into account the member's ability to travel to the practitioner rendering the second opinion.

Authorizations or denials are to be issued in an expeditious manner. Decisions and notifications will be made and a second opinion provided within the time frames appropriate to the type of request (i.e., urgent, non-urgent, concurrent, retrospective). If a member's condition is such that the condition is an imminent or serious threat to his/her health, including but not limited to, the potential loss of life, limb or other major bodily function the authorization is to be rendered within 72 hours of receipt.

If the second opinion request is about the care the member is receiving from their PCP, an appropriately qualified health care professional, and/or other licensed health care providers of the member's choice, should give the second opinion. The provider supplying the second opinion must be acting within the scope of practice and possess clinical background and expertise related to the member's illness or condition. The provider should be in the same IPA as the member's PCP.

If the member's request is about the care the member is receiving from a Specialist, an appropriately qualified health care professional, and/or other licensed health care providers of the member's choice, should give the second opinion. The provider supplying the second opinion must be acting within the scope of practice and possess clinical background and expertise related to the member's illness or condition. The

provider can be from any participating IPA within the Health Plans network. If the provider is not within the member's IPA, the Health Plan will incur the cost or negotiate the fee arrangement.

If there is no participating Health Plan provider/practitioner within the Provider Group's network or if the member or member's physician requests a second medical opinion outside of the Provider Group's network, they must be instructed to call the Health Plan's Customer Service number on the back of the member's ID card.

The second opinion provider is to provide a copy of the consultation report, recommended tests, and procedures to the initial provider and to the member.

Applicable to organization with Medicare contract: Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient, and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.

SPECIALIST TERMINATION / MEMBER NOTIFICATION / CONTINUITY OF CARE

- Specialists who intend to terminate their contract with Santé Physicians are required to provide 90 days notification. Notification of the specialist's termination is sent to all Primary Care Physicians. It is the responsibility of the PCP to redirect (refer) the member to an in-plan specialist. The PCP is provided with a list of alternative specialists to whom he or she may refer their members.
- If a member requires ongoing care from a specialist that has terminated their contract, the PCP submits a request for authorization for the member to see the now out-of-plan specialist. The request is subject to medical review.
- Continuity of care is assured for at least 30 days following the actual termination date of the specialist's contract for members for whom it is deemed medically necessary.
- Santé Physicians will provide to the Health Plan, upon request, the report of the members and PCP assignment that is provided to the PCP's.
- If the member has been assigned another provider and the terminated provider subsequently agrees to not terminate their contractual relationship. The provider group shall send a letter to the member offering the member the option to return to that provider. (Also see Policy 2:03)

Continuity of Care/ SB 1129 / SB 1746

Effective January 1, 2004, the State of California and the Department of Managed Health Care implemented a continuity of care law.

Covered services under continuity of care:

- At the member's request, a terminated provider may continue treatment for an acute medical condition and /or serious chronic medical condition (continuity of care for up to 90 days or a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Physician Organization in consultation with the enrollee and the terminated provider and consistent with good professional practice). Examples include, but are not limited to, surgeries scheduled during the first month of transition, ongoing care of home health services, fracture care, cancer care, mental illness, AIDS, CVA/stroke, head injuries, MS, etc.
- At the member's request, a terminated provider may continue treatment for high-risk pregnancy (all trimesters) until completion of postpartum delivery services.
- Terminal illness covered for the duration of the terminal illness.
- Care of a newborn child between birth and 36 months covered for 12 months from the contract termination date.
- Performance of a surgery or other procedure that is authorized as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.
- Behavioral Health care benefits as mandated under California Health & Safety code, mental health parity regulations.

Continuity of care guidelines may apply when:

- A newly covered enrollee member is receiving services from a non-participating provider at the time his or coverage became effective.
- A health care provider is no longer contracting with Santé Physicians.

Guidelines for Newly covered enrollees:

For all new enrollees, the health plan will communicate to their members that they must follow the normal, established procedures of their Medical Group in order to receive services.

- New enrollees are provided with "Santé Physicians Member's Guide." They are advised to call Santé Customer Service with questions related to their medical care.
- Possible COC cases are identified through calls received by the Customer Service department. Members are advised of the continuity of care guidelines. If the member feels they have a condition that qualifies under these guidelines, they are advised to have their provider contact our UM department to coordinate transition of care.
- The process for continuity of care and completion of services for newly enrolled members receiving services from non-participating practitioner(s) or provider(s) at the time coverage becomes effective with the organization. If not delegated, policy

would include statement of referring the member to the health plan as applicable. [Health & Safety Code §1373.95(2)]

Medi-Cal Member Transition from FFS to Medical Managed Care Plan (MMCP)

Members that transition into a MMCP, have the right to request Out of Network (OON) and Continuity of Care (COC) in accordance with State law and health plan requirements. [State Contract]

- Programs include:
  - Low Income Health Program (LIHP)
  - 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 as mandated by APL 018-008, 12-7-2018

- Assures continuity of care for dental, medical, behavioral health (BH), and long-term services and supports (LTSS).
- Enrollees can to maintain their current providers whether they are in network or out-of-network
- Enrollees can maintain their current providers and service authorizations at the time of enrollment for a period up to 12 months, for Medi-CAL services covered other than in-home supportive services (IHSS), DME, transportation, other ancillary services or carved out services, if all of the following criteria are met :
  - The enrollee demonstrates an existing relationship with the provider, prior to enrollment (staff will ascertain whether or not this exists); An existing relationship means the beneficiary has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the MCP for a non-emergency visit.
  - The provider is willing to accept payment from the organization based on the MP's rate for the services offered or applicable Medi-CAL rate, whichever is higher ;
  - The organization determines the provider meets applicable professional standards and would not otherwise exclude the provider from its provider network due to documented quality of care concerns.
- Enrollee can request, the enrollee's authorized representative or their provider, via telephone or in written form. (See Operations policy 02-029).
- OON and COC requests are processed within 5 working days of receipt of request and must be completed within 30 calendar days. When the medical

condition requires more immediate attention, the organization follows ICE Medi-Cal TAT Standards.
- Submission of quarterly reports to the health plan

Retroactive Requests for Continuity of Care shall be accepted and approved when the following factors are met:

- The criteria for Continuity of Care are met, with the exception of the requirement to abide by the organization's Utilization Management policies.
- The retroactively requested services must have occurred after the member's enrollment in the plan.
- The plan must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment.

Retroactive Requests for Continuity of Care Criteria

- Retroactive requests can only be approved if they meet the following criteria :
    - Have dates of service that occur after 12/29/2014
    - Have dates of service within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement
    - Are submitted within 30 calendar days of the first service for which retroactive continuity of care reimbursement is being requested

Continuity of Care Decision-Making

- When a request for continuity of care is made, the organization must:
    - Begin to process the request within five working days after receipt of the request. However, the request must be completed in three (3) days if there is a risk of harm to the beneficiary.
    - Must be completed within the following timeline
        a) 30 calendar days from the date the MCP received the request
        b) 15 calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs or
        c) 3 calendar days if there is a risk of harm to the beneficiary.
    - Upon approval of the continuity of care request, organization must notify the beneficiary of the following within seven calendar days :
        a) The request approval
        b) The duration of the continuity of care arrangement
        c) The process that will occur to transition the beneficiary's care at the end of the continuity of care period and
        d) The beneficiary's right to choose a different provider from the plan's provider network

Notification prior to end Continuity of Care

When a request for continuity of care is made, the organization must:

- Notify the beneficiary 30 calendar days before the end of the continuity of care period about the process that will occur to transition the beneficiary's care at the end to the continuity of care period
- Engage with the beneficiary and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider

Transition to New Organization and Continuity of Care Completion of Transition

Continuity of Care request is considered complete when:

- The enrollee is informed of his or her right to continued access and care coordination is performed;
- The organization and the out-of-network FFS or prior plan provider are unable to agree to a rate;
- The organization has documented quality of care issues; and
- The organization makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar day

Nursing Facility Services in CCI counties for Beneficiaries not enrolled in Cal MediConnect

Procedures that include the following, according to APL 15-004:

- Leave of absence and bed holds;
- Continuity of care according to APL 14-021
- Change in a beneficiary's condition and discharge;
- Authorization processes for Medi-CAL services including nursing facility provider authorization request processes

REFERRAL PROCESS

1. The member/client is seen by the Primary Care Physician.
2. The Primary Care Physician generates a written referral and forwards to Santé via fax/mail.
    a. Date received is stamped on referral upon receipt.
    b. Information is verified as to eligibility of the member. Referral is given to customer services if eligibility is not in system. Eligibility is then verified by customer service and returned to UM.
    c. When the referral is received requesting contracted specialists, the referral is data entered for claim payment.
    d. If a member is ineligible or service is not a plan benefit, the Primary Care Physician will be notified and the referral is denied. The Primary Care Physician is notified in writing.
    e. In cases where a member's benefits are exhausted but the member still needs care, Santé assists the member, if necessary, in obtaining other care. This may include:

- Referring the member to Case Management to assist transition to new provider
- Obtaining continued care through other sources, e.g. community resources
- Ancillary Provider Grids are maintained in Administrative Manual and distributed to Santé Community Physician's providers and Um staff.

f. Verification of contracted specialist provider. If non-contracted, the referral is pended and Primary Care Physician notified that prior authorization is needed.

g. If PCP office erroneously submits a referral request for a non-contracted specialist, the request is pended and the Primary Care Physician is notified that a prior authorization is needed.

h. If unauthorized referral to a non-contracted specialist has been completed, the Primary Care Physician is notified and the Primary Care Physician is responsible for any fees generated by the service.

i. If the service has not been provided by the specialist physician the referral is denied and the Primary Care Physician is instructed to request prior authorization with supporting documentation.

j. Retro referrals are not accepted.

3. Processing of the referral is completed in a timely manner 3 to 5 working days after receipt at Santé and/or specialty providers.
4. Referral processing does not interfere with or cause delay in service or preclude delivery of services.

OUT-OF-NETWORK REFERRALS:

In order to obtain the highest benefit, members must see providers that are within their provider network. Examples of out of network referrals:

- Service or Provider is not available in plan
- Participating provider or specialist unable to perform the service
- Member is unable to see in plan provider timely
- Participating provider is not taking new patients

Out-of-network referrals require prior authorization to determine medical necessity and availability. Prior authorization for out-of-network requests are reviewed by the Medical Director. If approved, Santé will generally pay for services performed by a non-participating provider with an approved prior authorization as if the provider were participating.

Verification of out-of-network/non-participating practitioners have not been suspended, made ineligible, excluded, sanctioned or opted out of participation under Medicaid, prior to the authorization of services utilizing the following sources:

UM staff will document prior auth requests with dates and initials of person reviewing exclusion/sanction reports.

1). Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) Database
- **https://exclusions.oig.hhs.gov** - enter the name/facility

2). SAM (System for Award Management) List
- **https://www.SAM.gov** - Click on "Search Records" then type in the name/facility

3). State Suspended & Ineligible List
- **www.medi-cal.ca.gov -** Click "References" from bar at top, choose "Suspended & Ineligible" from the list, click on link at bottom of page to open excel download. On a monthly basis State Suspended & Ineligible list will be down loaded and saved within the UM/Medi-CAL folder for staff access. Click last name field and use filter to look for your OON provider name

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

Medi-Cal / CCS Referrals

Policy: 5.10
Origination Date: 12/2015
Last Review Date: 01/2024

Purpose:

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.

Policy:

1. The Utilization Management staff will, whenever possible, identify all Medi-Cal members.
2. The Utilization Management staff will assist providers in timely identification of Medi-Cal members eligible for CCS program services.
3. The Utilization Management staff will assist the M.D. providers in referring potential CCS eligible Medi-Cal members to CCS.

Procedure:

1. The Utilization Management staff will identify Medi-Cal members by either unique SS# assignment or HMO plan codes. (Information provided by Health Plans.)
2. When a Medi-Cal member is identified as having a potentially CCS eligible condition, the Utilization Management Department will contact the members primary care provider (PCP) or Specialist and assist the provider in initiating the CCS referral process.
    - 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.

- Santé Physicians IPA referral log maintenance of all CCS referrals, and monthly transmission to the Medicaid Health Plan
- The responsibility for log maintenance and transmission to the Health Plan is clearly defined

Process – Evidence includes:

- Current list of CCS facilities and provider from DHCS website
- CCS education to new hires, providers and staff, inclusive of how to access/identify CCS facilities and providers via DHCS website, at least annually
    -

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

Medi-Cal / Medical Records Review

Policy: 5.11
Origination Date: 01/2019
Last Review Date: 01/2024

Purpose:

To ensure Medi-CAL PCP (Internal Medicine, General Practice, Family Practice, Pediatrics) OB/GYNs compliance with medical record standards for Medi-CAL programs such as (CCS, CPSP, CHDP, Sterilization Consent, EI/ES/DDS/Regional Center, IHA/IHEBA) requirements.

Policy:

- It is the policy of Santé Physicians to assess and improve, as needed, the quality of medical record keeping and documentation.

Procedure:

- Medical records reviews will be conducted on a quarterly basis.
- Medical records review will review 10-30 charts.
- Medical records review will follow file review tools.
- Medical records review results will be communicated to practitioner.
- Medical records review results will be reported on an annual basis.
- Medical record review results will be presented to UM Committee.
- If medical records review results minimum performance threshold of 95% is not attained, practitioner will be subject to a "Corrective Action Plan", educational intervention and a re-audit every six months until a 95% compliance threshold is reached.

SANTÉ PHYSICIANS IPA

Medicaid Policy/Procedure

DENTAL SERVICES – INTRAVENOUS SEDATION AND GENERAL ANESTHESIA COVERAGE

Policy: 5.12
Origination Date: 12/2019
Last Review Date: 01/2024

Purpose:
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.

Policy:
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.

The following lists the requirements for Santé Physicians to cover general anesthesia services:

1) Contractual responsibilities, as found in Exhibit A, Attachment 11 (*All Medi-Cal managed care boilerplate contracts are available here: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx),* Dental explain the following:
    a) MCPs must cover services related to dental procedures that require general anesthesia and are provided by individuals other than dental personnel, including any associated prescription drugs, laboratory services, physical examinations required for admission to a medical facility, outpatient surgical center services, and inpatient hospitalization services required for a dental procedure;

b) MCPs shall reimburse facility fees for services provided in any hospital, ambulatory surgery center, that meet the requirements set forth in this policy provided by either dental personnel or individuals other than dental personnel; and
c) MCPs must coordinate all necessary non-anesthesia covered services provided to a beneficiary.

2) Beneficiaries may receive treatment for a dental procedure provided under general anesthesia by a physician anesthesiologist in the settings listed below only if the MCP determines the setting is appropriate and according to the criteria outlined in Attachment A:
    a) Hospital;
    b) Accredited ambulatory surgical center (stand-alone facility);
    c) Dental office; and
    d) A community clinic that:
        i) Accepts Medi-Cal dental program (Denti-Cal or DMC plan) beneficiaries;
        ii) Is a non-profit organization; and
        iii) Is recognized by the Department of Health Care Services as a licensed community clinic or a Federally Qualified Health Center (FQHC) or FQHC look-alike.

3) Authorization for general anesthesia provided by a physician anesthesiologist to a beneficiary during an inpatient stay must be part of the authorization for the inpatient admission.

Attachment A

INTRAVENOUS SEDATION AND GENERAL ANESTHESIA GUIDELINES FOR DENTAL PROCEDURES

Patient selection for conducting dental procedures under intravenous (IV) sedation or general anesthesia utilizes medical history, physical status, and indications for anesthetic management. The dental provider in consultation with an anesthesiologist is responsible for determining whether a Medi-Cal beneficiary meets the minimum criteria necessary for receiving IV sedation or general anesthesia. The dental provider must also submit a Treatment Authorization Request (TAR) prior to delivering IV sedation or general anesthesia. However, a TAR is not required prior to delivering IV sedation or general anesthesia as part of an outpatient dental procedure in a nursing facility or any category of intermediate care for the developmentally disabled.

Additionally, the dental provider must meet the requirements for chart documentation, which includes a copy of a complete history and physical examination, diagnosis, treatment plan, radiological reports, the indication for IV sedation or general anesthesia and documentation of perioperative care (preoperative, intraoperative, and postoperative care) for the dental procedure.

Criteria Indications for IV Sedation or General Anesthesia

Behavior modification and local anesthesia shall be attempted first. If this fails or is not possible, then sedation shall be considered.
If the provider documents both number 1 and number 2 below, then the patient shall be considered for IV sedation or general anesthetic.

1. Failure of local anesthesia to control pain.
2. Failure of conscious sedation, either inhalation or oral.

If the provider documents any one of numbers 3 through 6 then the patient shall be considered for IV sedation or general anesthetic.

3. Failure of effective communicative techniques and the inability for immobilization (patient may be dangerous to self or staff).
4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
5. Patient has acute situational anxiety due to immature cognitive functioning.
6. Patient is uncooperative due to certain physical or mental compromising conditions.

If sedation is indicated then the least profound procedure shall be attempted first. The procedures are ranked from low to high profundity in the following order: conscious sedation via inhalation or oral anesthetics, IV sedation, then general anesthesia. 1

Patients with certain medical conditions, such as but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias, and significant bleeding disorders (continuous Coumadin therapy) should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis.

Providers will adhere to all regulatory requirements (Federal, State, Licensing Board, etc.) for:

- Preoperative and perioperative care
- Monitoring and equipment requirements
- Emergencies and transfers
- Monitoring guidelines