

## Section 7

### Utilization Management

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## Utilization Management Overview

### Program Scope

The Health Plan of San Mateo (HPSM) Utilization Management Program (“the UM Program”) encompasses management and evaluation of care across the continuum of care. This includes pre-service review and authorization, concurrent and retrospective review of inpatient care including acute care, rehabilitation and skilled nursing, pharmaceuticals, DME, and ambulatory services.

The UM Program is designed to promote the provision of medically appropriate care; to monitor, evaluate, and manage resource allocation; and to monitor cost effectiveness and quality of the healthcare delivered to our members through a multidisciplinary, comprehensive approach and process. The Utilization Management Program supports the HPSM mission.

- The mission of HPSM is to provide members with access to quality healthcare services delivered in a cost effective and compassionate manner.

Utilization and Resource Management functions are performed by HPSM’s Health Services Department. The Health Service Department’s vision is that services are designed around the member’s journey in the healthcare system with the goal to improve the member’s experience and health outcome.

## ORGANIZATION

### Background

The Health Plan of San Mateo (HPSM) was created in the mid-1980s by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a County Organized Health System (COHS) authorized by state and federal law to administer Medi-Cal (Medicaid) benefits in San Mateo County. Because it is based within the community it serves, HPSM is especially sensitive to, and its operation reflects, the unique health care environment and needs of San Mateo County’s Medi-Cal beneficiaries. In 2006, HPSM began a Special Needs Medicare Advantage Plan (MA SNP) which allows HPSM to offer the Medicare and Medi-Cal benefits under one umbrella to all dually eligible individuals. HPSM’s mission is to provide members with access to high quality services delivered in a cost-effective and compassionate manner.

Since opening its doors in October of 1987, HPSM has greatly improved access to healthcare for San Mateo County beneficiaries. At its inception, the organization’s primary focus was to serve the health care needs of San Mateo County Medi-Cal beneficiaries including nearly all Medi-Cal eligible individuals in the county, with membership including the TANF population as well as aged and disabled recipients. Over the years, HPSM has added additional product lines in response to community needs. HealthWorx serves In-Home Supportive Services (IHSS) workers and eligible San Mateo county temporary employees. In January 2009, HPSM became a third-party administrator for San Mateo County’s Access and Care for Everyone (ACE) program and in 2010 the Medicaid Coverage Expansion (MCE) Program was added. The San Mateo ACE and MCE Programs are coverage programs provided by the County of

San Mateo, which is committed to providing health care coverage to uninsured residents of the county. By taking on these additional groups and a state licensed Medicare program under a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS), HPSM has expanded and reaffirmed its commitment to providing health care to San Mateo County's most vulnerable residents.

### HPSM's Delivery System

HPSM is able to fulfill its mission in San Mateo County because of its successful partnership with its outstanding healthcare delivery partners. Medical services are delivered to our members through our directly contracted provider network. HPSM's network includes over 800 primary care physicians and over 1200 specialists. In addition, HPSM's network includes hospitals and medical centers located in San Mateo County and in neighboring San Francisco as well. While HPSM does not contract directly with its pharmacy network, HPSM delegates this responsibility to its contracted pharmacy benefits manager, DST.

### Scope of Services

HPSM provides a comprehensive scope of acute and preventive care services for San Mateo County's Medi-Cal, HealthWorx and dually eligible population. Certain services are not covered by HPSM or may be provided by a different agency. These are:

- Mental Health services are administered by the San Mateo County Health Services Agency (HSA) for Medi-Cal. HPSM contracts with San Mateo County's Behavioral Health and Recovery Services division for services for its other lines of business.
- Dental services are provided through California's Denti-Cal program for Medi-Cal members. Delta Dental contracts with HPSM to provide services for Care Advantage members.
- California Children's Services (CCS) is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS authorizes care and in San Mateo County, HPSM pays for medical services and equipment provided by specific specialists. The CCS program is funded with State, County, and Federal tax monies, along with some fees paid by parents or guardians.
- Childhood Health and Development Program (CHDP) is managed at the County level.
- HPSM works with community programs to ensure that members with special health care needs, high risk or complex medical and developmental conditions receive additional services that enhance their medical benefits. These partnerships are established through special programs and specific Memorandums of Understanding (MOU) with certain community agencies including the San Mateo County Health Services Agency (HSA), California Children's Services (CCS), and the Golden Gate Regional Center (GGRC).

## AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

1. The San Mateo Health Commission (SMHC) and the San Mateo Community Health Authority (SMHA) have ultimate accountability and responsibility for the quality of care and services provided to HPSM members. The Commission holds the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The CMO ensures separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced.
2. The CEO allocates financial and employee resources to fulfill the program objectives. The CEO delegates authority, when appropriate, to the CMO. The CEO shall ensure that the QMP satisfies all remaining requirements of the Quality Improvement (QI) Plan, as specified in the State Contract.
3. The CMO in collaboration with the Director of Health Services Operations is responsible for the Utilization Management Program. The CMO is also responsible for the Quality Management Program. At least quarterly, the CMO presents reports on Health Services activities to the Utilization Management Committee. The CMO chairs the Utilization Management Committee that reports to the Senior Executive team. The CMO works in conjunction with the CEO to oversee the quality reporting matrix that includes Utilization Management oversight, development of QI studies, and follow up on identified quality of care issues.
4. The Director of Health Services Operations is responsible for management of the Health Services Department. The CMO and the Director of Health Services Operations are the CEO's designees in the day-to-day implementation of Utilization Management and are responsible for ensuring that the program is properly developed, implemented and coordinated.
5. The CMO and the Director of Health Services Operations are responsible for day to day management and oversight of the utilization review process for all product lines for all members. The CMO and the Director of Health Services Operations work closely with the Care Coordination Unit Manager to assure members receive high quality, medically necessary care in a way that balances individual need and cost effectiveness in the short and long term.
6. The Care Coordination Unit Manager is accountable to plan, organize, develop and manage the care coordination system in Health Services. The Care Coordination Unit Manager's primary focus is on high risk members as identified through emergency and inpatient recidivism and also those members requiring complex medical care coordination. The Care Coordination Unit Manager interacts regularly with the provider community and outside agencies including but not limited to the Regional Centers, California Children's Services, County Mental Health, the County public hospital and Aging and Adult Services.
7. The Director of Pharmacy has management responsibility for overseeing pharmacy benefits operations activities, including Medi-Cal and Medicare Part D programs, formulary management, cost containment and reimbursement strategies, program administrative leadership, supervision of pharmacy staff, program development and policy enhancement.

8. The Provider Network Manager is responsible for provider network development, contracting, and provider relations management for contracted and non-contracted providers. The Provider Services Department is responsible for assuring that providers are able to efficiently deliver services to members and receive prompt reimbursement for services performed. The Provider Network Liaisons perform provider education and assist providers in problem resolution.
9. The CMO is responsible for the overall coordination of planning and evaluation services, including contract requirements and coordination of external quality review requirements. As part of this function, the CMO works in collaboration with the Chief Compliance officer to ensure that HPSM meets the requirements set forth by the Department of Health Care Services (DHCS), Department of Health Services Managed Medi-Cal Division (DHS/MMCD), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid (CMS), and the Managed Risk Medical Insurance Commission (MRMIB). HPSM's Compliance and Regulatory Affairs Department works in collaboration with HPSM's functional areas, such as Utilization Management and Grievance and Appeals, to evaluate the results of performance audits and to determine the appropriate course of action to achieve desired results. In addition, the CMO and the Director of Health Services Operations oversee the development and amendment of HPSM policies and procedures related to Utilization Management and Health Services to ensure adherence to state and federal requirements. Lastly, functions relating to fraud investigations are handled by the Compliance and Regulatory Affairs Department.

## PURPOSE OF THE UTILIZATION MANAGEMENT PROGRAM

The purpose of the Utilization Management Program is to define and describe HPSM's multidisciplinary, comprehensive approach to managing resource allocation through systematic monitoring of medical necessity and quality while maximizing the cost effectiveness of the care and service provided to members.

### **The Utilization Management Program will ensure that:**

- HPSM Health Services Utilization Management (UM) review staff utilize nationally recognized standard criteria and informational resources to determine the medical necessity of healthcare services to be provided (e.g., Medi-Cal Manual of Criteria issued by the State of California, Milliman Care Guidelines).
- HPSM Health Services UM review staff, that includes physicians, licensed nurses, and unlicensed trained employees, carries out the responsibilities designated for their level of expertise within their respective scope of practice, and as defined in their Job Position Descriptions.
- HPSM Utilization Management Program collaborates with the HPSM Quality Assessment and Improvement program to ensure ongoing monitoring and evaluation of quality of care and service, and continuous quality improvement.

- At least annually, the Utilization Management Program description, policies, and procedures are reviewed at one of the monthly medical management meetings, attending by senior management and it is also reviewed at the Quality Management Oversight Committee meeting. The UM Program is revised if necessary.

**Care Coordination Activities include the following:**

- Monitoring and assessing the delivery of care, including review and evaluation of medical necessity and appropriateness, under and over utilization of services, continuity and coordination of care, timeliness, cost effectiveness, and quality of care and service.
- Ensuring that members have access to the appropriate care and service within their health plan benefits and consistent with accepted standards of medical practice.
- Retaining the ultimate responsibility for the determination of medical necessity for HPSM members and ensuring that authorization requests are handled efficiently according to HPSM UM timeliness standards.
- Evaluating the results of the Utilization Management Program utilizing data includes:
  - Membership statistics
  - Quality and utilization management reports, such as bed day utilization, ambulatory care and ancillary utilization patterns.
  - Conducting regular monitoring visits with follow-up for quality improvement activities or corrective actions to ensure continued compliance with HPSM standards.
- Monitoring of services to evaluate utilization patterns.
- Monitoring performance to ensure qualified healthcare professionals perform all components of utilization review. Maintaining a process for a licensed physician to conduct reviews on all cases that do not meet medical necessity criteria, or service requests that are not addressed by criteria.
- Maintaining a process to ensure that all Health Services UM reviewers have access to appropriate board-certified specialists to assist in determining medical necessity as needed.
- Ensuring inter- and intra-rater reliability through a defined internal process.
- Ensuring the confidentiality of member and provider information.

**UM Program Goals**

The Utilization Management Program shall endeavor to promote the delivery of high-quality care in the most cost-effective manner for HPSM's members, and thus contribute to the achievement of the HPSM mission. The Utilization Program goals and objectives are:

- Improve the quality of care delivered to members by ensuring they receive the appropriate level and mix of medical services in the most appropriate setting- The right service at the right time at the right place for the right reason.

- Facilitate communication and develop positive relationships between members and contracted providers by providing timely appropriate utilization review processing.
- Identify members with special needs and ensure that appropriate care is delivered to them through collaboration with county partners. This will reduce overall healthcare expenditures by developing and implementing effective preventive care and health promotion programs.
- Identify actual and/or potential quality issues during utilization review activities and refer to the CMO.
- Ensure compliance with regulatory agencies.

### Program Structure

The Utilization Management Staff work collaboratively with contracted healthcare providers in the community, in an effort to assure the delivery of appropriate, cost effective, quality evidence-based healthcare. The Utilization Management Program necessitates the cooperative participation of all HPSM contracted healthcare providers, including physicians, allied healthcare professionals, hospitals, outpatient facilities as well as members to ensure timely and effective delivery of healthcare services. Several collaborative projects between the plan and our county partners have been implemented. These collaborative projects identify members with special needs and ensure that appropriate care is delivered to them. Collaborative projects include but are not limited to, the Care Transition program. The Care Transition project focuses on providing well-coordinated community-based senior services, including limiting gaps in care between inpatient and outpatient and community-based senior services. The Care Transition project's model is to improve transitional care between the hospital and home or skilled nursing facilities.

The Health Services Department is responsible for all UM processing for members in all programs. Leadership is provided by the Director of Health Services Operations, who directly supervises the Utilization Manager and Inpatient Review and Care Transition Supervisor. The Utilization Manager directly supervises the UM Nursing review staff and Authorization Specialists. The Director of Pharmacy supervises the pharmacy staff and day to day operations of pharmacy benefit management. The Care Coordination Unit Manager supervises the Nurse Case Managers, Care Coordination Technician and the day to day management of the Care Coordination unit.

The Health Services Department collaboratively contributes to the development and implementation of the HPSM Utilization Program, as well as supporting policies and procedures. This Utilization Management Program is developed in compliance with the California Department of Health Services, the Center for Medicare and Medicaid Services (CMS) regulations for Medi-Cal and Knox-Keene regulations 1300.70, and SB 59.

The Utilization Program is reviewed and evaluated for effectiveness at least annually by the CMO and the Director of Health Services Operations. Recommendations for revisions and improvement are made as appropriate and the subsequent annual Utilization Program is based on the findings of the annual program evaluation.

The Utilization Management Staff work collaboratively with contracted healthcare providers in the community, in an effort to assure the delivery of appropriate, cost effective, quality evidence-based healthcare. The Utilization Management Program necessitates the cooperative participation of all HPSM contracted healthcare providers, including physicians, allied healthcare professionals, hospitals, outpatient facilities as well as members to ensure timely and effective delivery of healthcare services. Several collaborative projects between the plan and our county partners have been implemented. Using a proactive approach, these collaborative projects identify members with special needs and ensure that appropriate care is delivered timely and efficiently. Collaborative projects include, but are not limited to, complex care management programs that address high risk care management of the medically frail dually eligible Care Advantage population, the Care Transitions program, and developmentally disabled targeted case management. Additionally, the program integrates a Clinical Pharmacy Outreach Program (CPOP), the Long-Term Care Clinical Management program, In Home Physician program, Medication Therapy Management and disease management.

### **Committee Organization and Reporting Structure**

The structure of the Utilization Management Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of the HPSM healthcare delivery. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect entities and multiple disciplines within the organization. The Organization Chart and the Program Committees Reporting Structure outlines HPSM’s governing body, HPSM senior management, as well as committee reporting structure and lines of authority. Position job descriptions and Committee policies/ procedures define associated responsibilities and accountability.

### **HPSM Utilization Management Workgroup**

The Utilization Management Workgroup promotes the optimal utilization of healthcare services while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The Workgroup monitors the utilization of healthcare services by HPSM members in all programs to identify areas of under or over utilization that may adversely impact member care. The Workgroup meets bi-weekly.

### **Role and Responsibility**

- Provides coordination of UM functions.
- Provides oversight for appropriateness and clinical criteria used to monitor care and services provided to HPSM members.
- Monitors data and reports and identifies opportunities for improvement of internal processes and systems.
- Measures and documents effectiveness of actions taken.
- Review and evaluation of data to identify under or over utilization patterns.
- Review care management issues related to continuity and coordination of care for members.

## Care Coordination Meetings

### *Role and Responsibility*

HPSM meets at least quarterly with other community partners to address issues regarding the coordination of healthcare delivery services involving the San Mateo County Mental Health Plan, California Children's Services (CCS), and Aging and Adult Services (AAS). HPSM does not provide Mental Health services for Medi-Cal members; the Department of Health Services utilizes other contracts to provide this care. HPSM also does not provide CHDP services but works closely with this agency to coordinate services. HPSM does reimburse for CCS services through its contracted providers. Memoranda of Understanding (MOU) exist between each of these community partners, which require quarterly meetings to clarify systems issues and coordinate the care of complex cases. The MOU clarifies responsibilities and establish protocols and procedures for the exchange of information and maintaining confidentiality. These quarterly coordination meetings are attended by representatives of each of the respective organizations.

- System-wide issues and specific cases are addressed to promote continuity and coordination of care between the medical and behavioral healthcare providers.

## Peer Review Committee/Physician Advisory Group (PRC/PAG)

The PRC/PAG provides guidance and peer input into the HPSM practitioner and provider selection process and determines corrective actions as necessary to ensure that all practitioners and providers that serve HPSM members meet generally accepted standards for their profession or industry. The PRC/PAG shall review, investigate, and evaluate the credentials of all internal HPSM medical staff for membership and maintain a continuing review of the qualifications and performance of all internal medical staff. The PRC/PAG includes practicing physicians from the contracted healthcare provider network. The PAG meets on a bimonthly basis while appropriate peer review committees meet on an ad-hoc basis as needed. The Chairperson of this committee is a physician member of the Commission.

### *Role and Responsibility*

- Provides linkage with practicing physicians in the community for input to HPSM Quality and Utilization Programs.
- Reviews of quality of care issues.
- Peer Review.
- Reviews provider trends as related to UM and Quality issues.
- Takes corrective actions, when necessary, to improve provider performance and optimize systems and processes.

## PCP Specialty Referral Process

### What Services Require a RAF?

RAFs are only required for members to see non-participating plan specialist providers for evaluation and treatment.

RAFs are not needed for members to see doctors for sensitive services, like OB/GYN services, family planning services, sexually transmitted disease/HIV testing/counseling services, or for emergencies. The following services do not require a RAF:

- E&M codes rendered in a SNF
- Emergency care
- Services to “special members” (see Section Two for definition of “special member”)
- Preventive services
- Minor Consent services – Minors without their parents’ consent may receive the following services:
  - Services related to sexual assault
  - Pregnancy and pregnancy related services
  - Family planning services
  - Drug and alcohol abuse counseling\* (see page 12)
  - Outpatient mental health services\* (see page 12)
- Obstetrical services and family planning services
  - Pregnancy planning
  - Birth control
  - Prevention of sexually transmitted diseases
  - Confidential testing for venereal disease
  - HIV counseling and testing
- Abortion services
- Services from an Indian Health Services (IHS) provider
- “Limited Services”
  - Chiropractic\*\*
  - Podiatry
  - Acupuncture\*\* (Medicare non-covered benefit)
  - Prayer or Spiritual Healers
  - Vision (Medicare non-covered benefit)
  - Eyeglasses\*\* (Medicare non-covered benefit)

Medi-Cal members are limited to two office visits for each of these specialist services in a single month. For additional visits in a single month or for any procedures (other than office visits), the specialist provider must obtain preauthorization by submitting a PAR to HPSM (see section on “Prior Authorization for Medical Services” below).

\*Minor consent services: Member must be 12 years old or greater to be able to consent for drug and alcohol abuse treatment. Member must be 12 years old or greater and mature enough to consent and is the victim of incest or child abuse or would present a threat of serious physical or mental harm to self or other without treatment for outpatient mental health services.

### *RAFs Required - San Mateo County ACE/MCE Programs*

San Mateo County ACE & MCE are programs available to uninsured residents of San Mateo County who are not eligible for coverage through Medicare, Medi-Cal, private insurance or other third-party coverage. ACE & MCE are coverage programs and are not considered health insurance. Services are primarily available through the San Mateo Medical Center and Ravenswood Family Health Center. A referral to other providers is only through the RAF prior authorization process.

### *Specialty Referral Process: PCPs*

The HPSM Specialty Referral Process enables the Primary Care Physician (PCP) to coordinate the process by which his/her patients receive care from specialists (also known as referral providers). When a PCP identifies the need for a specialty referral, the PCP may refer the member to a participating specialist provider without a Referral Authorization Form (RAF). Referrals to non-participating plan providers require a RAF from the PCP. To initiate the referral process, the PCP will complete a Referral Authorization Form which is available on the HPSM website [www.hpsm.org](http://www.hpsm.org). Sample forms are attached in Section 10 of this manual and are available from your Provider Network Liaison.

The Referral Authorization Form (RAF) is a valuable tool for physician case-management and control of specialty referrals. When in the opinion of the Primary Care Physician (PCP), a member needs to see a specialist provider; the member’s PCP will refer the member to a Specialist for consultation and treatment. The PCP is responsible for identifying the specialist provider and contacting the Specialist to assure that the member will be seen on a timely basis and will make arrangements for follow-up with the PCP. The PCP will refer to Specialists who are contracted with HPSM. In cases where the contracted Specialists are not available, the PCP may seek the Plan’s assistance in obtaining access to contracted Specialist Providers and/or the PCP may elect to refer to a Specialist that is non-participating (see “Referral to Non-Participating Providers” section below).

All of the following items in Part I of the RAF **MUST** be completed. If any of the following is missing or illegible, it will be returned to the PCP’s office for completion/clarification. This will delay the processing of the RAF. The required information includes:

Check the appropriate program on the left-hand column (one box)

- CareAdvantage
- Medi-Cal
- HealthWorx
- Date of the referral
- PCP's name and provider number
- PCP's phone number
- PCP's fax number
- PCP's signature
- Member's name and date of birth
- Member's address and phone number(s)
- Member's ID number (please do not use the member's Social Security Number)
- Diagnosis and ICD-10 code
- Reason for referral
- Specialist's name
- Specialist's address
- Specialist's phone number

If the PCP also has the Specialist's fax number, that may be included, but it is optional. In addition, there are two optional boxes located just above the area where the Specialist's name is indicated. These are the "Consult only" box and the "Standing Referral for 1 Year" box.

The "Consult only" box should only be checked if the PCP does not want the Specialist to determine the number of additional visits he/she needs in order to complete his/her treatment and evaluation of the referred member. If this box is checked, any additional visit to the Specialist must be accompanied by a new RAF issued by the member's assigned PCP. This optional box allows the PCP maximum control of Specialist provider visits. When a PCP issues a follow-up RAF for additional visits to the Specialist provider, please include in the "Reason for Referral" section that this is a follow-up visit.

The "Standing Referral for 1 Year" box should only be checked if the PCP has determined that the member has a chronic disease condition that requires the ongoing care of a Specialist for at least a period of 1 year. Chronic disease conditions that are eligible for standing referrals include:

- HIV infection/AIDS
- Chronic Hepatitis B/C infection
- Uncontrolled diabetes
- Uncontrolled hypertension
- Rheumatoid arthritis

- Parkinson's disease
- Multiple sclerosis
- Other degenerative neurologic diseases
- Chronic obstructive pulmonary disease
- Asthma
- Congestive heart failure
- Chronic pain syndrome
- Chronic renal failure
- Cancer
- Other chronic conditions will be considered on a case-by-case basis.

Upon completion of the required elements in Part I, the RAF should be faxed to HPSM Health Services at **650-829-2079**. Upon receipt of the RAF, the PCP will receive an auto-reply message indicating that HPSM Health Services has received the RAF. Please note: The auto-reply will only work if the PCP's fax number is not blocked. (If the PCP does not wish to receive an auto-reply message, the PCP should block his/her office fax number, either through the local phone provider or through the fax machine options menu.) The auto-reply message will include a statement as to the number of pages received in that particular fax transmission as well as a copy of a portion of the first page of the fax. If additional information is needed the provider will be contacted.

**IMPORTANT:** RAFs faxed to other fax numbers at HPSM will not be forwarded to Health Services and will not receive an auto-reply. Please use the HPSM Health Services fax line for RAFs.

RAFs can also be mailed to HPSM Health Services. HPSM Health Services mailing address is:

Health Plan of San Mateo  
Health Services Department  
ATTN: RAF Authorization  
801 Gateway Boulevard, Suite 100  
South San Francisco, California 94080

Mailed RAFs will not receive a response indicating that HPSM Health Services received the RAF.

**PLEASE NOTE:** Urgent RAFs will be end-dated on the date of initial visit as indicated on the RAF. All RAFs are authorized for a single specialist provider visit within three (3) months from the date of receipt at HPSM Health Services (except for urgent RAFs, which are end-dated on the date of initial visit as indicated on the RAF). A specialist provider visit must occur within the three (3) month time period. If a PCP knows that the specialist provider visit will be beyond the three-month time period, the PCP may extend the RAF expiration to the known date of the initial specialist visit. In order to do this, the PCP must complete the date of initial visit (under Part II) on the RAF.

Upon receipt of a completed Part I RAF, HPSM Health Services authorization staff review the RAF for the following:

- Member eligibility
- RAF issuing PCP is PCP of record
- Specialist provider to whom the member is being referred is a participating provider

If the RAF meets all three criteria, then it will be authorized and an authorization number will be affixed to the RAF. No specialist referral by an eligible member's PCP of record to a participating specialist will ever be denied. The authorized RAF will be faxed to the specialist provider's office as well as to the issuing PCP's office. PCP offices should not send unauthorized RAFs to the specialist provider's office since this generates confusion at the specialist's office and unnecessary phone calls to HPSM Health Services. HPSM Health Services will fax all authorized RAFs to the respective specialist's offices.

#### *Specialty Referral Process: Specialist Providers*

Upon receipt of an authorized RAF, the specialists should make the appointment with the member for the consultation. The specialist must check member eligibility on the date of service, as the RAF authorization is subject to member eligibility.

Unless either of the optional boxes ("Consult only" or "Standing Referral for 1 Year") is checked, after the initial consultation, the specialist can determine the number of additional visits required to complete the evaluation and treatment of the member's condition. This is limited to up to 12 additional visits within a 3-month time period. For visits beyond this limit, an additional RAF from the member's PCP will be required.

Upon receipt of the faxed RAF, the Specialist will receive an auto-reply message indicating that HPSM Health Services has received the RAF. Please note: The auto-reply will only work if the Specialist's fax number is not blocked. (If the Specialist Provider does not wish to receive an auto-reply message, he/she should block his/her office fax number, either through the local phone provider or through the fax machine options menu.)

**IMPORTANT:** RAFs faxed to other fax numbers at HPSM will not be forwarded to Health Services and will not receive an auto-reply. Please use the HPSM Health Services fax line for RAFs.

If the "Consult only" box is checked, the Specialist must request additional visits from the member's PCP. If the "Standing Referral for 1 Year" box is checked, the Specialist does not need to complete Part II of the RAF. A standing RAF will allow for unlimited Specialist visits within a period of 1 year from the receipt of the RAF at HPSM Health Services. Standing RAFs are only valid for the evaluation and treatment of members with chronic diseases (see list above). The Specialist Provider who accepts a standing RAF will be required to provide a report to the referring PCP at least on a quarterly basis, detailing the member's progress. This quarterly reporting is subject to auditing by the CMO and Director of Health Services Operations, to prevent abuse of the standing referral policy.

The answers to frequently asked questions (FAQs) about the PCP Specialty Referral process are available in an HPSM publication entitled “PDF Instructions,” available on the HPSM website or from your Provider Network Liaison. In addition, information booklets about the RAF process are available for members in English and Spanish. Please ask your Provider Network Liaison for more details.

### *Referrals to Non-Participating Providers*

PCPs should make every effort to refer HPSM members to a participating provider listed in our provider directory. The HPSM provider directory, updated annually, is available on our website and also in hard copy format. Please ask your Provider Network Liaison for a hard copy.

HPSM realizes that there are unique circumstances in which our participating provider network may not cover a particular specialized medical service that is medically necessary for evaluation and/or treatment of a member. In these situations, a referral to a non-participating provider may be authorized. Please indicate on the RAF the reason why a participating provider is unable to provide the requested service. If this information is not provided, the RAF processing may be delayed.

### *Automated Electronic Web-Based RAF Processing*

An automated electronic web-based RAF processing program is currently being developed. This will be a HIPAA-compliant online referral authorization system which will allow PCPs to enter RAFs directly into the system and receive instantaneous authorizations. It will also allow Specialists to query the RAF system to ensure that a member’s visit has been authorized. HPSM will notify providers when this system will be operational.

## **Administrative RAFs for Specialty Providers**

For all product lines (CareAdvantage, Medi-Cal, and HealthWorx) there will be a RAF free holiday for in network referrals. The RAF free holiday does not apply to out of network referrals.

RAF requirements will resume upon notification by the HPSM. The following information is provided for reference only and will be updated over the next few months.

Under special circumstances, members may seek healthcare services from a specialist provider without a referral from their assigned PCP. Specialist providers may request that HPSM authorize these services by submitting an Administrative Referral Authorization Form (AdminRAF) to Health Services for approval.

The following are some examples that would require Plan authorization of Specialist Provider Services with an AdminRAF:

- A member was discharged from an Emergency Room within three (3) calendar days prior to a Specialist visit. This exception to the normal RAF rule is to allow for ER urgent referrals to specialists without the need for a PCP visit. If the Specialist visit is beyond three (3) days, it will require a regular RAF, issued by the member’s PCP.

- A member is a resident of a long-term care facility and is unable to see his/her PCP for a RAF. In this case, a Specialist's visit may be authorized with an AdminRAF.
- A member is referred to an out of network provider for specialized services not available/performed by an in-network provider.

## Prior Authorizations for Medical Services

Prior Authorization is intended to ensure that the requested service is covered by the member's scope of benefits, that the provider of service is participating, and that the services are medically necessary. Services will also be reviewed to ensure that the most appropriate setting is being utilized and to identify those members who may benefit from our Care Coordination programs. Prior Authorization is subject to a member's eligibility and covered benefits at the time of service.

An authorization must be obtained from HPSM prior to rendering the requested service to ensure reimbursement. Reimbursement is still subject to member eligibility on the date of service. Please check the member's eligibility before providing any service using any of the methods listed in Section 2 of this manual. In the event of an emergency, HPSM must be contacted within 24 hours, or on the next business day.

Prior Authorization requirements apply to all lines of business.

**CareAdvantage Plan:** All Inpatient Admissions, DME, Skilled Nursing, non-emergency medical transportation and Home Health Care require a PAR. HPSM follows Medicare coverage guidelines. CareAdvantage requires ERs, hospitals and SNFs to fax admission face sheets upon admission of a CareAdvantage member.

For CareAdvantage members only, Emergency Departments, Hospitals and SNFs can use admission face sheets as a notification of admission.

### What medical services require a PAR?

Prior authorization requirements are determined by the HPSM Prior Authorization List for all lines of business.

In general, prior authorization is required for the following services:

- Inpatient Care - including hospital and rehabilitation services.
- Home Care and Home IV Therapy
- Hospice Care - General Inpatient
- Durable Medical Equipment, prosthetics and orthotics.

- Cardiac Rehabilitation after initial assessment (Note: HPSM physician referral required for the first visit.)
- Incontinence Supplies
- Care outside the HPSM service area
- Care at centers of excellence or specialty care centers.
- Transition of care situations for new members or for members when their provider has left the HPSM provider network (see section on “Continuity of Care”)
- Physical Therapy/Occupational Therapy/Speech Therapy – initial evaluation does not require authorization but an HPSM physician prescription is required.
- Podiatry
- Non-Emergency Medical Transportation with the exception of hospital to home and hospital to skilled nursing or long-term care facility.
- Outpatient and Inpatient surgeries
- All requests for referral to out of area and/or out-of-network providers or facilities.
- Advanced Imaging Studies: Prior Authorization requirements for imaging studies are determined by the Prior Authorization List

#### *Prior Authorization Process*

Primary Care Physicians, specialty care providers and ancillary providers who identify a need for medical services for an eligible HPSM member that requires a prior authorization should complete a PAR form.

The PAR is to be used to document needed identification information. Depending on the complexity of the request, clinical information sufficient to make a medical necessity determination should be documented on this form. In most cases, a copy of a recent office note or consultation summarizing the medical needs of your patient will help us to rapidly process the request. Information, which can facilitate prior authorization determinations, includes the following elements, as relevant to each individual case:

- Patient characteristics such as age, sex, height, weight, or other historical and physical findings pertinent to the condition proposed for treatment
- Precise information confirming the diagnosis or indication for the proposed medical service
- Details of treatment for the index condition, or any related condition, including names, doses and duration of treatment for pharmacotherapy, and/or detailed surgical notes for surgical therapy
- Appropriate laboratory or radiology results
- Office or consultation notes related to the proposed medical service
- Peer-reviewed medical literature, national guidelines, or consensus statements of relevant expert panels

- The medical need for care by a provider outside of the HPSM network
- Applicable CPT-4 and ICD-10 diagnosis codes
- Applicable CPT/HCPCS code(s) for the requested service/procedure
- Complete facility and service information (including facility provider number and location)
- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

Whenever possible, we ask that providers submit requests for prior authorization to HPSM seven (7) to ten (10) business days in advance of scheduled procedures. This will ensure that our Utilization Management staff have enough time to process and review your requests, and if needed, obtain appropriate additional information, without a need to potentially delay care to your patient. Fax all PAR request to fax number: **650-829-2079**.

Urgent Requests receive special attention. HPSM makes every effort to return authorization determinations quickly. Urgently needed care should never be delayed while awaiting prior authorization. Please do not hesitate to ask to speak directly to the CMO or the Director of Health Services Operations if you have any concerns that our process is interfering with the care your patient requires. Urgent PARs may be faxed to the HPSM Health Services Fax line: **650-829-2079**.

The "Urgent" designation is intended for cases in which the requested service must be provided as quickly as possible to avoid harm to the patient. At times, requests may be received as urgent because elective services were scheduled, but authorizations were not requested in advance. We will do our best to respond to such requests but may have to ask that such procedures be rescheduled if there is insufficient time to obtain the clinical information and complete the required review.

Definition of an "Urgent PAR" is one in which the requested service is medically needed within three (3) business days of submission. Abuse of Urgent PAR requests will be monitored. Please note: The auto-reply will only work if the provider's fax number is not blocked. (If the provider does not wish to receive an auto-reply message, he/she should block his/her office fax number, either through the local phone provider or through the fax machine options menu)

**IMPORTANT**: Urgent PARs faxed to other fax numbers at HPSM **will not be forwarded to Health Services** and will not receive an auto-reply. Please use the HPSM Health Services Fax line for urgent PARs.

For questions regarding the status of a submitted PAR, or questions regarding the authorization process, you may call HPSM Health Services Department at 650-616-2070. Calls are answered by Prior Authorization Specialists to facilitate communication of essential information. Peak telephone call volume typically occurs in the late morning or early afternoon on Mondays and Fridays. Telephone response times are generally best at other times of the day.

HPSM Health Services Department hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding company holidays.

Completed Prior Authorization Request (PAR) forms with supporting documentation should be mailed to:

Health Plan of San Mateo  
Health Services Department  
ATTN: PAR Processing  
801 Gateway Boulevard, Suite 100  
South San Francisco, CA 94080

Communication of approval of Urgent PAR requests will be via call.

### Deferred or Extension of a Prior-AUTHORIZATION REQUEST (PAR)

#### *Medi-Cal, CareAdvantage and HealthWorx*

After a submitted PAR is reviewed by a UM Review nurse and determined to require additional information in order to evaluate the medical necessity of the requested service, a notice will be sent to the originator of the PAR requesting the specific information needed. This notification will be sent within two (2) business days of reaching the decision to defer the PAR and in any case, no later than five (5) business days of receipt of the submitted PAR. The member is also notified of the deferral. The provider has twenty-one (21) calendar days, from the date of the deferral notice, to respond to the deferral with the requested information. If no information is received or the information received does not address the requested information, the PAR will be denied. Providers will receive a second written request for the needed information approximately two (2) weeks prior to the twenty-eight (28) day deadline. Please respond to the request for additional information accurately and timely, as HPSM is only allowed to defer a PAR once. Notifications of a PAR administrative denial are sent to both the originator of the PAR as well as the member.

#### *Denied PARs*

PARs denied for medical necessity must be reviewed by the Medical Director. Medically necessary health care services are those services provided by a licensed health care provider to diagnose or treat an illness, injury, or medical condition which the HPSM Medical Director determines to be:

- Appropriate and necessary for the diagnosis, treatment, or care of a medical condition;
- Not provided for cosmetic purposes;
- Not primarily custodial care (including domiciliary and institutional care);
- Not provided for the convenience of the member, the member's attending or consulting physician or another provider;
- Performed in the most efficient setting or manner to treat the member's condition

- Necessary as determined by an order of the court;
- Being within standards of good medical practice as recognized and accepted by the medical community.

Non-acute care and treatment rendered when there is no reasonable expectation of the member's improvement or recovery as determined by the HPSM CMO, using generally accepted medical standards shall be considered not medically necessary. Denial letters will be issued in accordance with DMHC/DHCS and CMS mandates and time frame standards.

## Care Coordination Program

The HPSM Care Coordination program strives to proactively coordinate for services and complex care to enable the best clinical and functional outcomes for our members. Through the inpatient concurrent review process, Care and Transition Coordination staff work with members, their families, Primary Care Physicians (PCPs), specialists and community resources to coordinate a comprehensive plan of care. HPSM Care Coordination staff understands the benefits available to each member and can facilitate the optimal use of those benefits. Participation in Care Coordination is voluntary, and a member can opt in or opt out at any time.

Not all patients benefit from Care Coordination services. Patients receiving care from a single physician often do not need an outside coordinator for that care. However, with increasing case complexity, and increasing numbers of loosely affiliated care providers, many patients with complex care needs benefit by having a designated Care Coordination staff member.

HPSM identifies cases for Care Coordination prospectively through health status surveys and referrals from care providers and concurrently through the analysis of claims and hospital admissions history. We also request that providers notify our Care Coordination staff of complex cases amenable to Care Coordination.

Once a case is identified, the Care and Transition Coordination staff will contact the treating providers to establish a case file. The Care Coordination staff member will work with the provider to coordinate services, identify benefits that have not been fully utilized and can advise the treatment team of important coverage limitations that may apply. Treating physicians are encouraged to call the Health Services Department and ask for the Care Coordination Manager to obtain assistance in arranging/coordinating care, or in advising on resources that might be available to meet a member's needs.

Care and Transition Coordination staff will generally become involved with:

- Transfers to tertiary care facilities or centers of excellence;
- Admissions or referrals to non-participating providers or facilities;
- Members with ongoing care needs in a rehabilitation center, SNF or home care.
- Members with frequent ER visits;
- Continuing care following discharge against medical advice; and
- Members with ongoing complex care needs or high cost diagnosis including but not limited to:
  - End Stage Renal Disease Requiring Dialysis or transplant

- Chronic Pain
  - Multiple Sclerosis, ALS, and other debilitating neurologic conditions
  - Hemophilia
  - High Risk Pregnancies
  - Cancer
  - HIV/AIDS, chronic viral infections
- Coordination of care for members requiring services from community agencies such as: The Early Intervention Program through Golden Gate Regional Center, rehabilitation programs, TB treatment programs and HIV special needs programs.
  - Providers may contact HPSM's Care Coordination Unit directly at **650-616-2060** or utilize the Case Management Referral form located on our website.

## Self-Referred Care

HPSM members who meet the criteria outlined below do not need a referral for the following health services provided through a participating provider:

### Screening Mammography

The United States Preventive Services Task Force recommends a screening mammography every two years with or without clinical breast examination among women age 50-74. HPSM covers screening mammography for women over the age of 40, and encourages women to discuss the potential risks and benefits of mammography with her PCP. Women members of HPSM may self-refer for mammography after the age of 40. A participating diagnostic imaging provider must be used for this service. The testing center will require a prescription from a requesting physician.

### OB/GYN Services

HPSM members may self-refer for routine primary and preventive OB/GYN services, care related to a pregnancy, or for the care of acute gynecological conditions, if that care is provided by a participating OB/GYN provider. HPSM will also cover the cost of care for conditions identified in the self-referred visit. It is expected that the OB/GYN physician will send to the member's PCP a summary of the services and treatment plan as well as copies of screening (Pap smear, mammogram) or diagnostic tests performed.

### Selected Routine Outpatient Diagnostic Services

The following procedures, when performed at a participating HPSM outpatient hospital or free-standing radiology facility do not require prior authorization. The ordering physician simply issues a prescription to the member and sends them to a participating facility. The PCP simply sends a referral to the participating specialist for the service to be provided.

- Audiology evoked potential studies (limited service under CareAdvantage)
- Cardiac procedures (electrocardiography and cardiac stress tests)
- OB/GYN testing (fetal non-stress test, amniocentesis, cordocentesis, chorionic villus sampling, fetal contraction test, fetal scalp blood sampling)

- Neurological studies (electroencephalograms, EMG, nerve conduction studies)
- Pulmonary function tests

Medi-Cal and HealthWorx Members have the option to self-refer for additional services listed below.

#### Family Planning

Members may self-refer for family planning services through a participating provider. Family planning services include advice for birth control, pregnancy tests, sterilization, or an abortion, tests for sexually transmitted infections, HIV testing and counseling, a breast cancer exam or a pelvic exam. Medi-Cal members may go outside of the HPSM network to any provider that accepts Medi-Cal.

#### HIV Testing and Counseling

Members can self-refer for HIV testing and counseling any time they have family planning services, or through one of the participating family planning providers. Medi-Cal members may go outside of the HPSM network to any provider that accepts Medi-Cal.

#### *TB Diagnosis and Treatment*

Members may self-refer for TB Diagnosis and Treatment to a county public health agency for diagnosis and/or treatment. Members can choose to use either their HPSM provider or the county public health agency for diagnosis and/or treatment, including Directly Observed Therapy (DOT).

#### *Immunizations*

Members may receive immunizations through the PCP or self-refer to public health clinics for immunizations. Public health clinics will make every effort to verify with the member's PCP that the member has not already received the immunization and supply the health plan with documentation of services along with the claim.

## Emergency and Urgent Care

The PCP is responsible for the care of their patients 24 hours a day, seven days a week. The PCP or designee must be available in their office or via phone or answering service to appropriately triage and evaluate all non-emergent care as defined in the "Access to Care and Services Policy" in Section 7 - Administrative Policies of this Manual.

HPSM members with a medical emergency should go to the nearest emergency room for care. HPSM provides coverage for emergency services that meet the "prudent layperson" standard without prior authorization of these services. In addition, HPSM will provide coverage for any ER service authorized by the PCP or HPSM authorized representative. The Member Contract requests that members notify their PCP and HPSM within 48 hours of receiving care for an emergency. Conditions that do not meet the specified definition of medical emergency below including urgent care services require a referral by the member's PCP.

HPSM and the prudent layperson standard defines a medical emergency as the sudden, unexpected onset of a medical or behavioral condition causing symptoms of sufficient severity that a prudent layperson with an average knowledge of medicine and health could reasonably expect, in the absence of immediate medical attention, to result in:

- Serious jeopardy to the afflicted person's life or health; or
- Serious jeopardy to the life or health of a pregnant woman's unborn child; or

- In the case of a behavioral condition, placing the health of such person or others in serious jeopardy; or
- Serious impairment to the afflicted person's bodily functions; or
- Serious dysfunction of any bodily organ; or
- Disfigurement.

Some examples of Medical Emergency include: apparent heart attack/stroke, difficulty in breathing, severe bleeding, blackout, convulsions, apparent poisoning, or fracture.

If a member self-refers to the emergency room, the HPSM Medical Director/designee will determine whether the presentation of symptoms was consistent with the above prudent layperson criteria and will state reasons in writing whenever this coverage is denied.

PCP notification is not required for emergency care but coverage can be ensured if the PCP authorizes such care.

## Long Term Care

### *Definition*

Beginning February 1, 2010, HPSM is responsible for long term care (LTC) authorizations, utilization management and payment of facility room and board charges. Approximately 1,300– 1,400 HPSM members are residents of long-term care facilities. HPSM has over 100 contracted LTC facilities in San Mateo County and surrounding counties. HPSM administers these services in accordance with current Medi-Cal guidelines.

HPSM is administratively and financially responsible for the authorization of LTC Prior Authorization Requests (LTC PAR) for all Medi-Cal eligible beneficiaries with a County Code of 41 (San Mateo) and health plan number (HCP) 503. LTC nursing facilities send all PARs for services for facility room and board services provided to HPSM members to HPSM's Health Services Department. HPSM's Health Services Department processes PARs for members who require admission to LTC facilities, including free standing or distinct part Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), ICF/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N) or sub-acute Facilities-Adult/Pediatric. PARs are processed in accordance with the applicable requirements of the California Code of Regulations, Manual of Criteria for Medi-Cal Authorization, the California Welfare and Institutions Code and HPSM's Policies and Procedures in accordance with contractual agreements.

### *Financial Responsibility Related to LTC*

The daily rate charge for LTC services is the responsibility of HPSM. The admitting facility is responsible for obtaining the necessary authorization for the facility daily rate from HPSM's Health Services Department according to the LTC PAR submission requirements. HPSM continues to be responsible for authorizing, monitoring, and reimbursing medically necessary Medi-Cal covered services that are not included in the daily rate.

### *Preadmission Screening Preadmission Screening and Resident Review (PAS/PASARR)*

Each HPSM Medi-Cal recipient applying for Nursing Facility (NF) admission is subject to PAS/PASARR Level I screening or evaluation either prior to admission or on the first day for which HPSM Medi-Cal reimbursement is requested. The admitting NF is responsible for performing the evaluations. The admitting NF is also responsible for making a referral for Level II evaluation when appropriate. Welfare and Institutions Code Section 9390.5 has required Preadmission Screening for every Medi-Cal recipient applying for admission to a Nursing Facility to determine if the recipient's condition requires institutionalization in a NF or whether he/she could remain in the community with support services. The NF will utilize PAS/PASARR Level I Screening Document (DHS 6170), Long Term Care Prior Authorization Request (Form 20-1), Minimum Data Set (MDS) Full Assessment Form) or Minimum Data Set (MDS) Quarterly Assessment Form, and PAS/PASARR Monthly Statistical Report. The NF will comply with applicable regulations in the Code of Federal Regulations, the Medi-Cal Long Term Care Provider Manual, the Welfare and Institutions Code and Title 22.

### *Plan of Care in Long Term Care*

All HPSM members admitted to LTC facilities shall have an individually written Plan of Care completed, approved and signed by a physician pursuant to Title 42, Code of Federal Regulations. The Plan of Care shall be maintained in the member's medical record at the LTC facility.

### *PAR Process and Criteria for Admission to, Continued Stay in, and/or Discharge from a SNF, ICF, ICF/DD, ICF/DD-H, ICF/DD-N, and Subacute Adult/Pediatric Facility*

HPSM's Health Services Department will process all request for admission to, continued stays in, or discharge from any LTC facility in accordance with the California Department of Health Services (DHS) standard clinical criteria for levels of services. Each level of care PAR processing procedure will be in compliance with applicable regulatory requirements.

### *On Site PAR Review, Long Term Care*

HPSM's Health Services Department may perform on site review for DP-NFs, Intermediate Care Facilities and sub-acute sites. On-site review may also be done at free standing NFs, when indicated; e.g., patterns of high service utilization, frequent acute hospitalization of members, large numbers of member complaints/concerns. PAR requirements will be in compliance with Title 22 California Code of Regulations and DHS Manual of Criteria for Medi-Cal Authorization.

### *Retroactive Authorization for PAR for Long Term Care Facility Daily Rate*

HPSM's Health Services Department shall process all requests for LTC retroactive authorizations and or continued stays for HPSM members in an SNF, ICF, ICF/DD, ICF/DD-H, ICF/DD-N, sub-acute facility-adult or sub-acute facility-pediatric pursuant to the California Department of Health Services standard clinical criteria for a skilled level or care. The LTC will submit the request for LTC PAR with the required clinical information and completed forms to the HPSM Health Services by mail or fax in accordance with applicable requirements of the California Code of Regulations, Title 22.

### *Quality Improvement Activities for Long Term Care*

HPSM's Quality Improvement program systematically manages the provision and continuous improvement in the quality and care of service provided to all HPSM members. Measures of quality care and service include the following: access to care, appropriateness of care, process of caring, health outcomes, and member and provider satisfaction.

Quality Assessment and Improvement (QAI) activities as related to members residing in Long Term Care facilities will comply with all state and federal requirements as specified in the contract between the state and HPSM. The QAI program focuses on evaluation and improvement of the quality of member care in all settings or levels of care and with primary care and specialty physicians. HPSM is not responsible for any facility oversight as currently carried out by the California Department of Licensing and Certification, or for the California Department of Health Services Field office responsibilities related to the Inspection of Care Adults.

HPSM assists in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for members in LTC facilities including, but not limited to, CCS, Mental Health, and Golden Gate Regional Center. In addition, communication to Licensing and Certification, Medi-Cal Operations Division and the LTC Ombudsman Office for potential quality of care issues may be a part of the QAI activities as indicated.

### *Complaints and Grievances*

LTC facility room and board charges are a Medi-Cal benefit now administered by HPSM. All HPSM members and providers have access to HPSM's state-approved Complaint and Grievance process. Members also have access to the State Fair Hearing process at any time. The mechanism by which an LTC facility can resolve member or provider issues related to the provision of Medi-Cal facility services to HPSM members will be amended as needed to include the LTC program services.

### *Occurrence Reporting to Licensing and Certification*

HPSM's Health Services and Quality Improvement Departments shall respond to occurrences, situations and complaints that affect or potentially affect the safety and well-being of HPSM members in LTC facilities by reporting the events to the appropriate regulatory agency for investigation.

### *Process for Transferring HPSM Members from Long Term Care Facilities to Acute Care Facilities*

An LTC facility shall be responsible for coordinating an emergent/urgent transfer of a HPSM member to an acute care facility. An LTC facility shall collaborate with all appropriate multidisciplinary team members to facilitate either a planned or emergent/urgent transfer of a HPSM member from an LTC facility to an acute care facility. The LTC facility shall notify HPSM's Health Services Department of the admission of a HPSMM member to the acute care facility on the next business day.

### *Process for Transferring HPSM Members from Acute Care Facilities to Long Term Care Facilities*

The acute care facility in collaboration with HPSM shall be responsible for all discharge planning aspects of a HPSM member's transfer to an LTC facility. HPSM's Health Services Department shall

assist in coordinating the discharge planning of the member from an acute care facility to an LTC facility. The acute care facility shall collaborate with all appropriate multidisciplinary team members to facilitate the transfer of the member. The admitting LTC facility shall notify HPSM's Health Services Department of the admission of the member. The admitting LTC facility shall coordinate the medical and ancillary services with HPSM's Health Services Department and/or appropriate agency, e.g., California Children Services (CCS) and the local Regional Care Center, as appropriate.

#### *Distinct Part Nursing Facility Authorization*

The Hudman vs. Kizer court order applies to all eligible Medi-Cal recipients/HPSM members in need of long-term skilled nursing care.

Distinct Part/Nursing Facilities (DP/NF) shall be reimbursed at the DP/NF rate when the medical necessity for long term nursing care has been documented and all administrative requirements have been met as described in the Department of Health Care Services (DHCS) Long Term Care manual.

#### *Leave of Absence*

A Leave of Absence (LOA) may be granted to a recipient in a Nursing Facility (NF) Level A or NF Level B, NF Level A-DD-N and NF Level A-DD-H in accordance with the recipient's individual plan of care and for the specific reasons outlined in the DHCS Long Term Care manual.

Leaves of absence may be granted for the following reasons: a) a visit with relatives or friends; b) participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons.

#### *Bed Hold for Acute Hospitalization*

If a recipient is admitted to an acute care hospital, a Bed Hold (BH) may be permissible under the conditions outlined in the DHCS Long Term Care manual.

#### *Summer Camp Leave Bed Hold Reimbursement*

Skilled nursing and intermediary care facilities may receive reimbursement for developmentally disabled (DD) recipients attending summer camp.

To qualify for reimbursement, the facility must meet the following criteria: a) the patient's attendance at camp is prescribed by a licensed physician and approved by the appropriate regional center for the developmentally disabled; b) the patient is not discharged from the facility while attending camp; c) the facility holds the patient's bed during the period of absence; d) the term of absence at camp plus any other accumulated leave days for the calendar year (not including acute care stays) do not exceed 73 days per calendar year.

The bed hold will terminate and discharge status will take effect under the following circumstances: a) if a patient dies while at camp, the bed hold terminates on the day of death (discharged date is the day of death); b) if a patient is admitted to an acute care hospital from camp, the bed hold terminates on the day of departure from camp; c) if the patient leaves camp and does not return to the skilled nursing

facility, the bed hold terminates on the day of departure from camp.

### *Patient Plan of Care Requirements*

Skilled nursing and intermediate care facilities must include written Plans of Care in each patient's medical record.

Individual written plans are required by Title 42, Code of Federal Regulations (CFR) to be approved and signed by a physician. They should include: a) diagnosis, symptoms, complaints and complications; b) description of individual's functional level; c) objectives; d) orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures; e) plans for continuing care; and f) plans for discharge.

### *Skilled Nursing Facility Written Plan of Care*

Before admission of a patient to a SNF or before authorization for payment, the attending physician must establish a written Plan of Care for each applicant or recipient in a SNF. The Plan of Care must include: a) diagnoses, symptoms, complaints, and complications indicating the need for admission; b) a description of the functional level of the individual; c) objectives; d) any orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the patient; e) plans for continuing care, including review and modification to the Plan of Care; f) plans for discharge.

The attending or staff physician and other personnel involved in the recipient's care must review and sign each Plan of Care at least every 60 days.

### *Intermediate Care Facility Written Plan of Care*

Before admission of a patient to an ICF or before authorization for payment, a physician or staff physician must establish a written Plan of Care for each applicant or recipient.

The Plan of Care must include: a) diagnoses, symptoms, complaints, and complications indicating the need for admission; b) a description of the functional level of the individual; c) objectives; d) any orders for: medications, treatments, restorative or rehabilitative services, activities, therapies, social services, diet, and special procedures designed to meet the objective of the Plan of Care; e) plans for continuing care, including review and modification of the Plan of Care; f) plans for discharge. The team must review and sign each Plan of Care at least every 90 days.

## **Long Term Care Clinical Management**

The Health Plan of San Mateo's Clinical Management program systematically manages the provision and continuous improvement in the quality and care of service provided to all HPSM members. Measures of quality care and service include the following: access to care, appropriateness of care, process of caring, health outcomes, and member and provider satisfaction. The clinical management activities as related to members residing in Long Term Care facilities comply with all state and federal

requirements as specified in the contract between the state and Health Plan of San Mateo. The clinical management program focuses on evaluation and improvement of the quality of member care in all settings or levels of care and with primary care and specialty physicians. HPSM is not responsible for any facility oversight as currently carried out by the California Department of Licensing and Certification, or for the California Department of Health Services Field office responsibilities related to the Inspection of Care Adults.

HPSM does assist in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for members in LTC facilities including, but not limited to, CCS, Mental Health, and Golden Gate Regional Center. In addition, communication to Licensing and Certification, Medi-Cal Operations Division and the LTC Ombudsman Office for potential quality of care issues may be a part of the QAI activities as indicated.

## Child Health and Disability Program (CHDP)

### *Program Description*

The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

Effective July 1, 2010 HPSM is responsible for the processing and reimbursement of the PM 160 claims for all HPSM eligible Medi-Cal members. Providers will not submit claims to State CHDP for HPSM eligible Medi-Cal members.

### *Reimbursement*

HPSM reimburses at the current the CHDP maximum allowable rates.

### *Claims and Claims Processing*

Providers must use the *PM 160 Information Only* (brown form) for HPSM eligible Medi-Cal members. Providers will continue using the *PM 160* (green form) for Gateway eligible Medi-Cal beneficiaries and submit these claims to State CHDP for processing.

PM 160 claim information and payments are included in HPSM's regular Explanation of Payment (EOP). During claims processing, PM 160 claim codes are converted to their corresponding CPT codes and shown on the EOP service lines. PM 160 claim services lines are identified with Explanation Code CH "CHDP Claim – Paid at Maximum Allowable"

Mail completed *PM 160 Information Only* (brown forms) to:

Health Plan of San Mateo  
Attn: Claims Department  
801 Gateway Boulevard, Suite 100  
South San Francisco, CA 94080

## Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

EPSDT is codified in federal law and creates a benefit that provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal. The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting.

HPSM may not impose service limitations other than medical necessity. Medical necessity for children is defined as necessary health care, diagnostic, treatment and other measures to *correct or ameliorate defects and physical and mental illnesses and conditions* discovered by the screening services, whether or not such services are covered under the plan. The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. Since medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements. Additional services must be provided if determined to be medically necessary for an individual child. HPSM must provide case management and targeted case management.

HPSM has a responsibility to provide health education, including anticipatory guidance, to members under age 21 and to their parents or guardians in order to effectively use those resources, including screenings and treatment. HPSM must conduct outreach to ensure providers are trained and adhere to Bright Futures guidance.

Providers are required to refer Members to appropriate diagnostic and treatment services following either a preventative screening or other visit that identifies the need for follow-up.

### **EPSDT covers:**

- Early and periodic screening, diagnostic and treatment (EPSDT) services.
  - Well-child visits which are a comprehensive set of preventive, screening, diagnostic, and treatment services.
  - HPSM will make appointments and provide transportation to help children get the care they need.
  - Preventive care can be regular health check-ups and screenings to help find problems early. Regular check-ups aid in identifying any problems with medical, dental, vision, hearing, mental health, and any substance use disorders. HPSM covers screening services any time there is a need for them, even if it is not during the regular check-up. Preventive care can also include shots; HPSM must make sure that all children enrolled get needed shots at the time of any health care visit.
    - Screening: (i) comprehensive health and development history (inc. assessment of physical and mental health development); (ii) a comprehensive unclothed exam; (iii) appropriate immunizations according to age and health history; (iv) lab test (including BLL); (v) health education (inc. anticipatory guidance)

- Screening services must identify developmental issues as early as possible.
- When a problem is found during a check-up or screening, HPSM covers the care that is medically necessary to correct or help any physical or mental health issues. All of these services are at no cost to the member and include:
  - Doctor, nurse practitioner, and hospital care
  - Shots to keep the member healthy
  - Physical, speech/language, and occupational therapies
  - Home health services, which could be medical equipment, supplies, and appliances
  - Treatment for vision and hearing, which could be eyeglasses and hearing aids
  - Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
  - Case management, targeted case management, and health education
  - Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance.
- If the care is medically necessary and HPSM is not responsible for paying for the care, then HPSM will coordinate care to help members get the right care they need. These services include:
  - Treatment and rehabilitative services for mental health and substance use disorders
  - Treatment for dental issues, which could be orthodontics
  - Private duty nursing services

## Complex Care Management

Complex care management uses proactive care management principles. High risk members are identified through a predictive model and health risk assessment and other screening tools. Complex/high risk care management programs focus on providing well-coordinated community-based services, including limiting gaps in care between inpatient and outpatient and community-based services. The framework of the care management programs address the complexity of the healthcare system and the difficulty our member's encounter navigating the health care system- Limited ability to access services negatively affects health status. Goals of our care management programs include a) improving quality of care, b) improving member satisfaction and c) promoting the provision of medically appropriate care through a multidisciplinary, comprehensive approach in a cost-effective manner. For our dually eligible population, Care Advantage, each member receives a health risk screening assessment annually. In addition to the member's subjective health risk assessment screening tool, a comprehensive assessment is performed on high risk medically complex members. The integration of the comprehensive assessment with the health risk assessment screening tool serves as a basis in development of individualized care plans. Individualized care coordination interventions are documented in a relational database that fosters centralized information and standardization. Care management interventions are developed in conjunction with the member and include a point of contact at the plan responsible for communications with the member. The health

risk assessment screening is communicated with the member's primary care physician. Collaboration and coordination of care with the primary care physician is an integral component of the care management program.

Complex Care Management/Care Coordination Activities include the following:

- Comprehensive health risk assessments are performed for each Care Advantage member and high risk Medi-Cal members. This tool is the foundation of the case management process. Assessment and data gathering includes but is not limited to member demographics, primary care physician and specialty physician care information, living status, hospitalization and ED utilization, a review of physiological health systems, past medical history, a medication history and medication regimen, medication therapy management eligibility, social/emotional status, functional status/disability rating, activities of daily living assessment, exercise assessment, fall risk, community resource utilization and assessment, and primary care giver assessment, durable medical equipment ( DME) and medical supply assessment and a needs assessment summary.
  - The clinical history documents the members' health status, clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history and current and past medication.
  - Activities of daily living evaluate the members' functional status related eating, bathing, walking, toileting, and transferring.
  - Mental health status evaluates the members' mental health status, including psychosocial factors and cognitive functions such as ability to communicate, understand instructions and process information about their illness.
  - Cultural and linguistic needs include an assessment of cultural and linguistic needs, preference or limitations.
  - Caregiver resources are evaluated to assess family involvement in the care plan and the caregiver potential for burn-out.
  - Life planning assessment addresses life planning issues such as living wills/ advance directives/ durable power of attorney.
  - A benefit assessment is also conducted.
- Individualized care plans are developed from the findings and analysis of the comprehensive health risk assessments.

## In-Home Physician Program Through HomeAdvantage

The In-Home Physician program is a system of care that provides 24/7 access to in-home physician

visits for the plan's most medically vulnerable and complex members. This program supports proactive cost management and enhanced medical care by treatment through a home delivery system by optimizing care in the home. The services that In-Home Physician program provides include:

- 24/7 patient access to a visiting physician.
- Regularly scheduled in-home and facility visits and anytime as needed.
- Coordinated care with primary care physicians, specialists, and the plan's nurse Care Manager.
- Clinical and pharmacy management.
- Education to the patient about their medical conditions and anticipated outcomes.

## Care Transitions

The plan also incorporates a care transition model in the Care and Transition Coordination program. The intent of the care transition model is to improve health care outcome and reduce re-hospitalization risk when members encounter a care transition. Members experiencing a care transition from the home to an acute care setting or to a skilled nursing facility are identified and followed by the nurse case manager and a care transitions coach through the continuum of care. The nurse case manager and/or care transitions coach serves as a point of contact to the member and the member's health care team. For each care transition, the nurse case manager and/or care transitions coach also initiates communication to the member's primary care physician. The primary goal of the nurse case manager and/or care transitions coach is to support the member and the member's healthcare team to ensure appropriate communication and benefit coordination occurs in a timely manner.

## Medication Therapy Management (MTM)

Medication Therapy Management is the analytical, consultative, educational and monitoring services provided by pharmacists to Care Advantage members in order to facilitate the achievement of positive therapeutic and economic results from medication therapy. MTM services allow pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs, and provide healthcare to plan members in a cost-effective manner.

HPSM contracts with the vendor, SinfoniaRx, to administer MTM services. MTM services include comprehensive medication review (CMR), prescriber communications, member compliance consultations, and member education and monitoring.

Comprehensive medication review is performed annually. During the CMR, a pharmacist will review the member's prescription and nonprescription medication, vitamins, minerals, herbal products, and dietary supplements for potential interactions. As part of the review, a master medication list will be provided to the member to bring to future office visits.

Prescriber communications assist physicians and other prescribers to coordinate care and resolve potential medication-related complications. These communications may include a phone call or fax to the prescriber's office with information and/or recommendations concerning a member's drug therapy regimen.

Member compliance consultations assist members with compliance issues. MTM pharmacists monitor plan members for compliance with prescribed medications. When an overuse, underused, or administration issue is identified, the pharmacist will educate the member on the importance of compliance and monitor the member to ensure that compliance improves.

Member education and monitoring is performed when a member is prescribed a new medication therapy or experiences a change in therapy. MTM pharmacists monitor the member for improvement in reportable symptoms, the occurrence of the side effects and compliance with therapy.

## Terminated Providers

HPSM has a mechanism to continue appropriate and timely care for members whose physicians are terminating from the network. This process includes a 60-day notification from the practitioner of the intent to terminate. Members under current care and those with approved prior authorizations, not yet utilized, are identified so that their care can be managed and coordinated with the receiving physicians. Members, such as those undergoing cancer treatments of chemotherapy or radiation therapy, dialysis-dependent members, those awaiting transplants, late-term pregnancies, pending surgeries, acute rehabilitation, and any other members that might have their ongoing care negatively impacted by the termination of the group are identified. When members are identified as possibly benefiting from coordination of care both within and outside of the network, the case is referred to the CCM for further interventions. The CCM actively engages in activity that monitors and assesses continuity and coordination of clinical care. The CCM works closely with the member, physicians and any other associated ancillary providers involved in the case, in an effort to provide timely, quality-based care meeting the needs of the individual member.

## Behavioral Health Management

HPSM ensures that members with coexisting medical and behavioral healthcare needs have adequate coordination and continuity of their care throughout the network.

HPSM works closely with the San Mateo County Mental Health Plan as well as other county programs such as San Mateo County Behavioral Health and Recovery Services, Golden Gate Regional Center, and California Children's Services to coordinate medical and behavioral care for members.

Continuity and coordination of behavioral healthcare may involve HPSM communicating and coordinating care directly between PCPs and Behavioral Health specialists. The HPSM Care Coordination Case Manager and other related Health Services staff are responsible for coordinating

services with San Mateo County Mental Health to ensure that individual members with coexisting medical and behavioral disorders receive appropriate treatment in the appropriate ambulatory and/or inpatient setting.

## Prescription Medication Prior Authorizations

HPSM has a process in place to ensure that procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and to make medical necessity exceptions to the HPSM formulary (HPSM Approved Drug List).

The HPSM Pharmacy Staff and the Pharmacy and Therapeutics Committee are responsible for development of HPSM Approved Drug List, which is based on sound clinical evidence and reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the HPSM Approved Drug List are communicated to both members and providers.

If the following situations exist, HPSM will consider the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate and the drug is medically necessary
- Member has failed treatment or experienced adverse effects on formulary drugs
- Member's treatment has been stable on a non-formulary drug and change to formulary drug is medically inappropriate.

To request a prior authorization (PA) for outpatient medication not on the HPSM Approved Drug List, the physician or physician agent must provide documentation to support the request for coverage. Documentation must be provided on the prescription request form, available on the HPSM website, which is submitted to HPSM's pharmacy unit for review. The initial review is based on PA guidelines approved and established by HPSM.

The pharmacy review staff profiles drug utilization by member to identify instances of poly-pharmacy that may pose a health risk to the member. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

## Monitoring for Consistent Review Criteria

The Health Services Utilization Review Manager and Care Coordination Manager perform ongoing monitoring of UM nurse reviewer application of criteria/guidelines to:

- Measure the reviewers' comprehension of the review criteria and guideline application process.
- Ensure accurate and consistent application of the criteria among staff reviewers, and ensure criteria and guidelines are utilized per policy/ procedure.

- Ensure a peer review process for inter-rater reliability.

The Health Services staff is responsible for identification of potential or actual quality of care issues, and cases of over- or under-utilization of healthcare services for HPSM members during all components of review and authorization.

## Monitoring for Over and Under Utilization

In an effort to review appropriateness of care provided to members, HPSM tracks and trends various data elements to determine over- and/or under- utilization patterns. The industry benchmark rates are used as guidelines for comparison. Some of the elements reviewed include:

- Hospital admits/1,000
- Re-admissions
- Pharmacy utilization
- Bed days/1,000, using HPSM performance standards
- Emergency room visits
- Encounters per enrollee per year
- Behavioral Health inpatient admissions
- Denials
- Frequency of selected procedures, as determined by utilization patterns
- Medi-Cal Medical Directors Utilization Reports
- Industry Collaborative Effort Utilization Reports
- Cultural/Linguistic reports that reflect barriers for access to care or delivery of care

HPSM enacts actions to improve performance as a result of these clinical data analysis, and feedback is provided to both entities and individual practitioners so that corrective actions can be taken. HPSM continues to monitor for compliance with corrective action plans and improvements in the care delivery process.

## Review Criteria, Guidelines, and Standards

Standards, criteria and guidelines are the foundation of an effective Utilization Management Program. They offer the licensed UM staff explicit and objective "decision support tools," which are utilized to assist during evaluation of individual cases to determine the following:

- If services are medically necessary
- If services are rendered at the appropriate level of care
- Quality of care meets professionally recognized industry standards
- Consistency of UM decisions

The following standards, criteria, and guidelines are utilized by the Health Services UM review staff and Medical Director as resources during the decision-making process:

- Medical necessity review criteria and guidelines
- Length of stay criteria and guidelines
- Clinical Practice Guidelines
- Policies and Procedures

## Decision Support Tools

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment and application of individual case information and local geographical practice patterns.

Licensed nursing review staff applies professional judgment during all phases of decision-making regarding HPSM members.

"Decision Support Tools" are intended for use by qualified licensed nursing review staff as references, resources, screening criteria and guidelines with respect to the decisions regarding medical necessity of healthcare services, and not as a substitute for important professional judgment.

The HPSM Medical Director evaluates cases that do not meet review criteria/guidelines, and is responsible for authorization/ denial determinations.

HPSM's Health Services UM review staff clearly document the Review Criteria/Guidelines utilized to assist with authorization decisions. In the event that a provider should question a medical necessity/ appropriateness determination made, any criteria, standards, or guidelines applied to the individual case supporting the determination is provided to the provider for reference.

The following approved department "Decision Support Tools" have been implemented and are evaluated and updated at least annually.

## Criteria and Guidelines

Approved HPSM Guidelines shall be used for all medical necessity determinations. HPSM uses the following criteria sets: Medi-Cal Manual of Criteria, published by the State of California, American Academy of Pediatric Guidelines (AAP), Milliman Care Guidelines, Medicare Coverage manual and the HPSM Medical Policy and Medi-Cal Benefits Guidelines ( Medi-Cal Provider manuals- Allied Health, Inpatient/Outpatient, Medical, Vision, Pharmacy) .

Due to the dynamic state of medical/healthcare practices, each medical decision must be case-specific based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care such as OB/GYN, surgery, etc. are primarily appended for guidance concerning medical care of the condition or the need for the referral.

### *Medi-Cal Manual*

The State of California publishes *Medi-Cal Manual of Criteria*, which is the basis for Medi-Cal benefit interpretation and used as a UM guideline.

### *Milliman Care Guidelines Criteria*

Milliman Care Guidelines are developed by generalist and specialist physicians representing a national panel from academic as well as community-based practice, both within and outside the managed care industry.

Milliman's clinical staff of physicians, nurses, and other healthcare professionals creates initial drafts of the criteria based on input from consultants, as well as an exhaustive review of existing guidelines and medical literature. Physicians and other providers from all disciplines relevant to the particular subject then review, revise, and re-review these versions in an iterative, consensus-building process (a modification of the Delphi method). Criteria acknowledge controversial areas where agreement cannot be reached and provide a rationale for the stance that has been chosen. Detailed notes and literature references provide the clinical basis for decisions. The criteria therefore provide a synthesis of evidence-based data, literature-supported medicine, and national consensus. Milliman criteria enable health plans and providers to capture data about the intervention requested and the rationale for each request. The criteria also provide a clinical reference for managing the dialogue between provider and reviewer, provider and payer, and provider and patient. Milliman criteria support an explicit, clinical rationale for care decisions.

Milliman guidelines update cycles are done at a minimum on an annual basis. Milliman states that update reviews include development of new procedures, new technology, requests from clients, criteria incorporating high frequency, high risk, high visibility and high variation, literature review and analysis, new clinical practice. (Milliman, 2007)

## **Utilization Management Appeals Process**

An organization determination is any decision made by or on behalf of HPSM regarding the payment or provision of a service a Member believes he or she is entitled to receive. An organizational determination is made in response to a Prior Authorization Request or a request for Prior Authorization submitted by a provider and may include approval, denial, deferral, or modification of the request. HPSM has a comprehensive review system to address matters when members or providers (on behalf of members for services yet to be provided) wish to exercise their rights to appeal an organizational determination that denied, deferred or modified a request for services.

The administration of HPSM's reconsideration of an organization determination and appeals process is the responsibility of the Grievance and Appeals Coordinator under the direct supervision of the Grievance and Appeals Manager. All investigation efforts are geared to protect the enrollee's privacy and confidentiality and to achieve rapid resolution.

## Confidentiality

Due to the nature of routine UM operations, HPSM has implemented policies and procedures to protect and ensure confidential and privileged medical record information. Upon employment, all HPSM employees, including contracted professionals who have access to confidential or member information sign a written statement delineating responsibility for maintaining confidentiality. Both the HPSM UM staff voice mail phone message line for utilization review information and the computer network system are controlled by a secured password system, accessible only by the individual employee.

The facsimile machines used for utilization review purposes are located within the department to assure monitoring of confidential medical record information by HPSM UM staff. HPSM has implemented Health Information Portability and Accessibility Policies and Procedures to guide the organization in HIPAA compliance. All records and proceedings of the UM Committee related to member or provider specific information are confidential and are subject to applicable law regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58.

## Conflict of Interest

**HPSM maintains a Conflict of Interest policy to ensure that conflict of interest is avoided by staff and members of Committees. This policy precludes using proprietary or confidential HPSM information for personal gain, or the gain of others, as well as a direct or indirect financial interest on or relationship with a current or potential provider, supplier, or member; except when it is determined that the financial interest does not create a conflict.**

Fiscal and clinical interests are separated. HPSM and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

## Staff Orientation, Training and Education

HPSM seeks to recruit highly qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program as applicable to specific job description:

- HPSM New Employee Orientation
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Utilization Management Program, policies/procedures, etc.
- Care Coordination Model of Care, policies and procedures

- MIS data entry
- Application of Review Criteria/Guidelines
- Appeal Process
- Orientation to specific programs of each delegated entity.

HPSM encourages and supports continuing education and training for employees, which increases competency in present jobs and/or prepares employee for career advancement within the HPSM. Each year, a specific budget is set for continuing education employees.

Licensed nursing staff is monitored for appropriate application of Review Criteria/ Guidelines, processing referrals/ service authorizations, and inter-rater reliability. Training opportunities are addressed immediately as they are identified through regular administration of proficiency. Training, including seminars and workshops, are provided to all UM staff regularly during regularly scheduled meetings and on