

SUBJECT: UTILIZATION MANAGEMENT PROGRAM		
The following MemorialCare affiliates that have adopted this: <input checked="" type="checkbox"/> Policy & Procedure or <input type="checkbox"/> Policy (only) or <input type="checkbox"/> Procedure (only)	<input type="checkbox"/> MemorialCare <input type="checkbox"/> Community Medical Center Long Beach <input type="checkbox"/> Long Beach Medical Center <input type="checkbox"/> Miller Children’s & Women’s Hospital Long Beach <input type="checkbox"/> Orange Coast Medical Center <input type="checkbox"/> Saddleback Medical Center <input type="checkbox"/> MemorialCare Medical Foundation <input checked="" type="checkbox"/> MemorialCare Select Health Plan <input type="checkbox"/> Memorial Medical Center Foundation <input type="checkbox"/> Saddleback Memorial Foundation	REFERENCE: UM 1500 S
		PAGE: 1 OF: 48
		EFFECTIVE: 11/30/2018
MANUAL:	SHP Select Utilization Management/UM	
OWNER:	Utilization Management Department	

Table of Contents

I.	POLICY	3
II.	DEFINITIONS.....	5
III.	PROCEDURE	9
A.	PROGRAM SCOPE.....	9
B.	PROGRAM GOALS	10
C.	PROGRAM ORGANIZATION.....	11
D.	UTILIZATION MANAGEMENT COMMITTEE.....	13
E.	UTILIZATION MANAGEMENT CRITERIA	15
F.	COMMUNICATION SERVICES	18
G.	REFERRAL AND AUTHORIZATION PROCESS	19
H.	BEHAVIORAL HEALTHCARE TRIAGE AND REFERRAL.....	30
I.	BEHAVIORAL HEALTH AUTHORIZATION PROCESS.....	31
J.	NOTIFICATIONS TO MEMBERS AND PROVIDERS.....	32
K.	STANDING REFERRALS	34
L.	RECONSTRUCTIVE AND COSMETIC SURGERY	35
M.	EMERGENCY AND POST STABILIZATION CARE	36
N.	HOSPICE AND PALLIATIVE CARE	39
O.	EXPERIMENTAL AND INVESTIGATIONAL SERVICES.....	40
P.	CANCER CLINICAL TRIALS.....	41
Q.	TERMINAL ILLNESS.....	42
R.	EVALUATION OF NEW TECHNOLOGIES.....	43
S.	MENTAL HEALTH PARITY	45
IV.	DOCUMENTATION	46
A.	UMC COMMITTEE MINUTES WILL:	46
B.	UM REFERRAL DOCUMENTATION	47
C.	DOCUMENTATION OF APPROPRIATE REVIEWER	47
V.	REFERENCES/AUTHORITY	48
VI.	ATTACHMENT	48

I. POLICY

- A. The purpose of the Utilization Management Program is to assure the delivery of medically necessary, optimally achievable, quality patient care through appropriate utilization of resources in a cost effective and timely manner to all members. To ensure this level is achieved and/or surpassed, programs are consistently and systematically monitored and evaluated. The evaluation process is fully documented and when opportunities for improvement are noted, recommendations are provided. The program description includes the scope of the program and the process and information sources used to make determinations of benefit coverage and medical appropriateness. MemorialCare Select Health Plan provides ongoing monitoring and evaluation activities which address and correct over and underutilization and inefficient coordination of medical resources. All Utilization Management processes are conducted under confidential protocols.
- B. Medical decisions are made by qualified individuals and with the use of criteria that is evidence-based and supported by clinical principles and processes without undue influence on plan management concerned with MemorialCare Select Health Plan's fiscal operation. The UM Program also ensures that contracting physicians are not penalized for authorizing appropriate medical care and referrals. MemorialCare Select Health Plan does not reward practitioners, vendors, or other individuals for issuing denials of coverage of care or service. There are no financial incentives for UM decision makers to encourage decisions that result in underutilization. Providers are not restricted from advocating on behalf of the member, or advising a member regarding care.
- C. The program ensures that Utilization Management decision making is based solely on appropriateness of care and services, and the existence of benefit coverage. MemorialCare Select Health Plan considers the needs of the individual such as age, co-morbidities, and complications, progress of treatment, psychosocial situation and home environment when applying criteria.
- D. MemorialCare Select Health Plan ensures telephone access by UM representatives during normal business hours for members and practitioners to request authorizations and to discuss UM issues. (CA Health and safety Code 1367.01 (i))
- E. UM Referrals will be processed in a way that will not interfere with or cause delay in service, or preclude delivery of service. Clinical information will be reviewed as part of the decision process. It is MemorialCare Select Health Plan policy that the Commercial UM Referral Process will be documented according to federal and state requirements. MemorialCare Select Health Plan follows the most current ICE Commercial UM timeliness standards to meet federal and state requirements for decision and notification timeliness. MemorialCare Select Health Plan will provide complete written or telephonic notifications to practitioners and members regarding UM decisions within regulatory guidelines.

- F. It is MemorialCare Select Health Plan's policy that protocols will be used to make triage and referral decisions related to behavioral health and substance abuse care, including urgency and appropriate setting. All triage and referral decisions are made by licensed and qualified practitioners. Supervision and oversight are performed by licensed and experienced practitioners. MemorialCare Select Health Plan provides hospital, medical and surgical coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions, including but not limited to: maximum lifetime benefits; copayments; and Individual and family deductibles.
- G. MemorialCare Select Health Plan has a process for authorizing standing referrals for members who need continuing care from a specialist and require specialized care over a prolonged period of time for the purpose of having the specialist coordinate the enrollee's health care, including HIV/AIDS.
- H. MemorialCare Select Health Plan provides 24-hour access for members and providers, including noncontracted hospitals, for the purpose of timely prior authorization for medically necessary and post stabilization care.
- I. MemorialCare Select Health Plan covers reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease that is necessary to either improve function or create a normal appearance to the extent possible.
- J. MemorialCare Select Health Plan does not cover experimental services. MemorialCare Select Health Plan does not cover investigational services except when it is clearly documented that all of the following apply; (1) conventional therapy will not adequately treat the intended member's condition; (2) conventional therapy will not prevent progressive disability or premature death;(3) the provider of the proposed service has a record of safety and success that is equivalent or superior to that of other providers of the investigational service; (4)the investigational service is the lowest cost item or service that meets the member's medical needs and is less costly than all conventional alternatives;(5) the service is not being performed as a part of a research study protocol; (6)and there is a reasonable expectation that the investigational service will significantly prolong the member's life or will maintain or restore a range of physical and social function suited to activities of daily living For any denial for treatment, services or supplies deemed experimental to an enrollee with a terminal illness, MemorialCare Select Health Plan communications to the member will meet defined requirements.
- K. New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease; are scientifically proven to be safe and efficacious; and there is no equally effective or less costly alternative.

- L. MemorialCare Select Health Plan will comply with all confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a) (13) and 422.118]

II. DEFINITIONS

- A. **Appeal** is a formal request by a practitioner or member for reconsideration of an adverse decision such as a utilization recommendation, with the goal of finding a mutually acceptable solution.
- B. **Behavioral Health** is a term for Mental Health services which may include substance abuse, chemical dependency for inpatient and outpatient. This broad term may also include evaluation and treatment of psychological and substance abuse disorders by either PCP or Behavioral Health providers.
- C. **Case Management** is the process for identifying covered persons with specific health care needs in order to facilitate the development and implementation of a plan to efficiently use health care resources to achieve optimum member outcome.
- D. **Clinical Trials** in cancer therapy are conducted to decrease morbidity and mortality from cancer. New drug development is one part of this effort, but other parts include the integration of multiple treatment modalities, the testing of new combinations of existing drugs, the testing of new dose schedules and routes of administration, the application of new diagnostic tests in choosing treatment regimens, and the evaluation of supportive care methods.
- E. **Cleft Palate** is a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
- F. **Cosmetic surgery** is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
- G. **Concurrent Review** is an assessment which determines medical necessity or appropriateness of services as they are being rendered. This may include inpatient level of care or an ongoing outpatient course of treatment
- H. **Criteria** mean principles or standards by which something may be judged or decided.

- I. **Delegation** is a formal process by which a Managed Care Organization (MCO) gives another entity the authority to perform certain functions on its behalf. The authority may be delegated but the responsibility for assuring that the function is performed appropriately cannot be delegated.
- J. A **Denial** is the decision to refuse, deny or modify a request for services/referral.
- K. **Discharge Planning** determines the need for services after the hospital stay and the availability of these services. Examples: home care, nursing home care, rehabilitative care, out-patient medical treatment.
- L. **Emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
 - 1. Placing the patient's health in serious jeopardy
 - 2. Serious impairment to bodily functions
 - 3. Serious dysfunction of any bodily organ or part
- M. **Exigent circumstances** exist when a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function or when a member is undergoing a current course of treatment using a non-formulary drug.
- N. **Experimental services** are those drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans.
- O. **Generally accepted standards** of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.
- P. A **grievance** is an expression of dissatisfaction by a member, either written or oral.
- Q. **Hospice** service or hospice program is a specialized form of Interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an enrollee who is experiencing the last phases of life due to the existence of a terminal disease.
- R. **Inpatient** refers to medical, surgical, OB and mental health services rendered in a facility. It may or may not include services provided in subacute/acute rehab facilities.

- S. **Investigational services** are those drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress but:
1. Testing is not complete; and
 2. The efficacy and safety of such services in human subjects are not yet established; and
 3. The service is not in wide usage.
- T. **Length of Stay (LOS)** means the number of days from admission to discharge, excluding the last day of the stay and any denied days.
- U. **Medically necessary or medical necessity** means health care services that a physician, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating illness, injury, disease or its symptoms, and that are:
1. In accordance with generally accepted standards of medical practice
 2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease, and
 3. Not primarily for the convenience of the member, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.
- V. **Overutilization** means provision of services that were not clearly indicated, or provision of services that were indicated in either excessive amounts or in a higher-level setting than appropriate.
- W. **Palliative Care** is the treatment and relief of mental and physical pain without curing the causes, especially in patients suffering from a terminal illness
- X. **Peer Review** is evaluation of the performance of colleagues by professionals with similar types of degrees and/or specialty.
- Y. **Pre-Service or Prospective** review means the process to determine medical necessity and benefit coverage of a request preceding the time of service. To include process to refer to a non-contracted provider if a contracted provider is not available.
- Z. **Promising** means preliminary scientific data supports reasonable likelihood of success of the treatment for the diagnosis.
- AA. **Psychiatric emergency medical condition** means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

1. An immediate danger to himself or herself or to others
 2. Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.
- BB. A **Qualified Physician or Practitioner** is required to have:
1. Graduated from a school of medicine, school of osteopathy or professional school applicable to the provider specialty
 2. A valid, current, unrestricted professional license to practice medicine in the state of California
 3. Valid current CA Drug Enforcement Agency (DEA) registration
- CC. **Reconstructive surgery** is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
1. To improve function
 2. To create a normal appearance, to the extent possible
- DD. **Reliable Evidence** means published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure.
- EE. **Representative** is an individual the member has authorized to act on his or her behalf and/or a person who has Durable Power of Attorney for Health Care of the member.
- FF. **Retrospective Review** is assessment of the appropriateness of medical services on a case-by-case basis or aggregate basis after the services have been provided.
- GG. **Serious emotional disturbances of a child** means a child (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and statistical manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behaviors inappropriate to the child's age according to expected developmental norms and (2) who meets the criteria in the Welfare and Institutions Code.
- HH. **Seriously debilitating** means diseases or conditions that cause major irreversible morbidity.
- II. **Specialty care center** means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
- JJ. **Standing referral** means a referral by a primary care physician through MemorialCare Select Health Plan to a specialist for more than one visit to the specialist, as indicated in the

treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

- KK. A member is **stabilized or stabilization** has occurred when, in the opinion of the treating provider, the member's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.
- LL. **Terminal illness** refers to an incurable or irreversible condition that has a high probability of causing death within one year or less.
- MM. **Turn around Time (TAT)** is the amount of time (usually days) from the receipt of a request/referral until the determination is made.
- NN. **Underutilization** is the failure to provide appropriate services.

III. PROCEDURE

A. PROGRAM SCOPE

The MemorialCare Select Health Plan Utilization Program includes management and evaluation of care and services in all settings, including doctors' offices and clinics, ambulatory or day surgery centers, hospitals, skilled nursing facilities, rehab centers and care provided in the home. The program includes activities such as pre-authorization of services, the review of member care while in a facility setting, and post service review of all care including, but not limited to facility, outpatient or office care and prescription drugs. The program also includes member support through case management of complex medical care, chronic condition and disease management. The UM Program uses care coordination, referrals and member education to help ensure that members receive medical care at the right time, in the right location, and by the right caregiver for the best clinical outcome and within the benefits available.

UM activities include, but are not limited to

1. 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, quality of care and service, and outcomes.
2. Ensuring that members have access to the appropriate care and service within their health plan benefits that is consistent with accepted standards of medical practice

3. Retaining the ultimate responsibility for the determination of medical necessity for MemorialCare Select Health Plan members
4. Ensuring that denials related to utilization issues are reviewed and handled efficiently according to MemorialCare Select Health Plan timeliness standards.
5. To determine if the UM program remains current and appropriate, the organization annually evaluates
 - a) The program structure.
 - b) The program scope, processes, information sources used to determine benefit coverage and medical necessity.
 - c) The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program.
 - d) The organization considers members' and practitioners' experience data when evaluating its UM program. The organization updates its UM program based on its evaluation.
6. Identifying, educating, and managing members with select chronic conditions, promoting increased member participation in disease self-management, improving quality of life for members, and reducing acute exacerbations of their illness
7. Monitoring IPA and Medical Groups delegated for UM activities and reporting time frames determined by MemorialCare Select Health Plan, and conducting regular provider audits with follow up as needed to ensure continued compliance with MemorialCare Select standards.
8. Monitoring performance to ensure qualified healthcare professionals perform all components of the UM Program
9. Maintaining a process for licensed physicians, psychiatrists or licensed mental health professional to conduct reviews on cases that may not meet medical necessity criteria
10. Maintaining a process that promotes UM staff, MemorialCare Select Health Plan and delegated Medical Group's Medical Directors access to appropriate board certified specialists as needed in determining medical necessity
11. Defining and monitoring the process used to avoid conflict of interest by staff reviewers and committee members
12. Ensuring the confidentiality of member information

B. PROGRAM GOALS

1. To provide ongoing monitoring/evaluation activities which address and correct over/underutilization and inefficient coordination of medical resources.
2. To maintain a systematic process for educating practitioners regarding utilization management issues
3. To ensure that government and other regulatory agency guidelines, standards and criteria are adhered to when applicable.
4. To promote and maintain cost-effective quality care through use of established, evidence-based clinical guidelines

5. To ensure that services rendered are within the guidelines of and are authorized by the member's health plan benefits and delivered by contracted, credentialed providers/practitioners.
6. To promote early identification, intervention, and referral to the appropriate level of care
7. To facilitate communication and develop positive relationships between members, practitioners, and medical groups by providing education related to appropriate utilization.
8. To ensure that a designated senior physician has substantial involvement in the implementation of the UM program
9. That MemorialCare Select Health Plan and its delegated medical groups consider the local delivery system when making UM decisions. Examples would be skilled nursing facilities, home health and behavioral health services.
10. To evaluate and monitor healthcare services provided by MemorialCare Select Health Plan contracted/credentialed providers through tracking and trending data
11. To identify members with special care needs and facilitate the delivery of appropriate care
12. To identify actual and/or potential quality issues during utilization review activities and refer to MemorialCare Select Health Plan Quality Improvement for investigation, follow-up and resolution.
13. To recommend and formulate changes in medical policy, guidelines, and procedures as a result of utilization-pattern analysis and industry trends.

C. PROGRAM ORGANIZATION

1. **BOARD OF DIRECTORS:** responsibilities include the development, maintenance and oversight of the Utilization Management (UM) Program. The responsibility for creating and implementing the UM Program's infrastructure may be delegated to the UM Committee (UMC) which will report to the Governing Body on at least a quarterly basis via report from the Quality Council.
2. **CHIEF MEDICAL OFFICER:** is a designated senior physician with a current unrestricted license to practice medicine in the state of California. The Chief Medical Officer ensures that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers/practitioners prior to, retrospectively, or concurrent with the provision of health care services to members, complies with regulatory requirements (1367.01(c))

The CMO responsibilities include the development, implementation and supervision of the UM Program, setting policies, reviewing cases, chairing the UMC committee

and participating in multiple sub-committees. The CMO provides guidance to UM staff and is responsible for evaluating the overall effectiveness of the UM Program.

3. A designated Behavioral Healthcare Practitioner is actively involved in the behavioral healthcare aspects of the UM program including collaboration on UM Behavioral Healthcare policies, reviewing UM Behavioral Healthcare cases and participating in the UM Committee and meetings. The behavioral healthcare practitioner must be a physician or have a clinical PhD or PsyD, and may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable). (NCQA UM 1, 2018)
4. UTILIZATION MANAGEMENT DIRECTOR: is a registered nurse with a current unrestricted license to practice in the state of California. The Utilization Management Director is responsible for the operational execution of the UM Program under the direction of the Chief Medical Officer.

The UM Director responsibilities include the development, implementation and evaluation of the Utilization Management Program and work plan and reports QM activities to the Chief Medical Officer, Utilization Management Committee and the Quality Council.

This position is also responsible for the day to day operations and management of staff assigned to UM, Case Management and Care Coordination activities for MemorialCare Select Health Plan, including monitoring and reporting as required by regulation or contract. Managing the UM staff which may include, but not limited to

- a) UR Coordinator
- b) UM Nurse
- c) Case Management Coordinator
- d) Case Manager
- e) HMO Coordinator
- f) UM Clerk

5. STAFFING

- a) Staff responsibilities, role descriptions and staff ratios are tied to work needs at MemorialCare Select Health Plan and its delegated medical groups. Licensed medical professionals supervise all UM Program activities. The UM Supervisors provide day to day supervision of assigned UM staff, participate in staff training, monitor for consistent application of UM criteria by UM staff for each level and type of UM decision, monitor documentation for adequacy and are available to UM Staff on site or by telephone.

- b) Licensed Registered Nurses and Vocational Nurses may approve UM referrals that require clinical judgment and meet current MemorialCare Select Health Plan approval criteria. Referrals that do not meet criteria are sent to a physician for review.
 - c) The program is supported by a staff of non-licensed employees. These employees perform a variety of non-clinical/administrative functions such as providing support to the professional clinical staff; data entry; creation of letters, reports and files; verification of member eligibility and benefits; and serving as the initial point of contact for members and providers for UM activities
 - d) Non-licensed staff members, under the supervision of appropriately licensed health professionals, may authorize approvals that meet MemorialCare Select Health Plan's current list of auto authorizations and do not require any clinical judgement. Referral requests that do not meet this criteria and require any clinical judgment must be sent to a UM nurse or physician for review.
6. The organization distributes a statement to all members, providers and employees who make UM decisions affirming the following:
- a) UM decision making is based only on appropriateness of care and service and existence of coverage
 - b) The organization does not specifically reward practitioners or other individuals for issuing denials of coverage
 - c) Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
7. All UM Management and staff are required to sign a Separation of Medical Services from Fiscal and Administrative Acknowledgment every 2 years.

D. UTILIZATION MANAGEMENT COMMITTEE

1. Meeting Frequency
The UMC will meet monthly with urgent issues addressed separately, as needed, by the Chief Medical Officer and /or subcommittee.
The Utilization Management committee reports to the Quality Council which in turn reports to the Governing Body at least quarterly.
2. UMC Composition
 - a) At least 3 practitioners of primary care and specialty care must be represented as regular committee attendees.

- b) A behavioral health provider is involved in the implementation of the behavioral health aspects of the UM Program and as an ad hoc member of the UM committee.
- c) The Chief Medical Officer is an active participant in the UMC meeting
- d) A voting quorum is present at each meeting and only physicians are voting on medical decisions
- e) Practitioner participation in the UM Committee meeting discussions represent a broad spectrum of specialists as appropriate in relation to the clinical discussions scheduled to take place.
- f) The UM Committee members will serve one year terms with the possibility of re-appointment.

3. UMC Responsibilities

- a) Ensure practitioner participation in the UM program through planning, design, implementation and review. Physician consultants from appropriate areas of medicine, surgery, behavioral health and additional specialty sources are available to review cases pertaining to their specialty.
- b) Review/approval of UM Program, UM Workplan, UM Annual Evaluation, and UM Semi-Annual Reports
- c) Review and approval of policies and procedures
- d) Review of UM statistics: e.g. Admits/1000, Bed-days, LOS by clinical service category and/or ICD/CPT, adverse outcomes, utilization, readmissions, high risk/high volume diagnoses/procedures, ER utilization, rates of selected referrals, procedures, pharmacy and utilization patterns for over/under utilization
- e) Review of denials and appeals
- f) Tracking and trending of referral turnaround time
- g) Review of any issues referred to the UMC, including sentinel events
- h) Ensure that UM IRR audits are conducted
- i) Review/approval of UR criteria and revisions, if necessary
- j) Review of inpatient/outpatient referrals
- k) Review of new medical technology
- l) Review of emergency services
- m) Member and practitioner satisfaction with the UM process
- n) Evidence of appropriate communication to all contracted providers and members
- o) Review of any delegated functions
- p) Identification of issues, corrective action plan formulation, follow –up and reevaluation as applicable.
- q) The UMC is linked to Quality Council as well as other departments including QM, Member Services, and Credentialing, Provider Network Operations, Claims, IT and Pharmacy.

E. UTILIZATION MANAGEMENT CRITERIA

1. The criteria or guidelines used by MemorialCare Select Health Plan including their delegated medical groups and any contracted entities that include utilization management functions to determine whether to authorize, modify or deny health care services shall:
 - a) Be developed with involvement from actively practicing health care providers
 - b) Be consistent with sound clinical principles and processes
 - c) Be evaluated, and updated if necessary, at least annually. If new scientific evidence is not available, a designated group may determine if further review of a criterion is necessary
 - d) If used as the basis of a decision to modify, delay or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specific case.

2. MemorialCare Select Health Plan utilizes written UM criteria that are consistent with accepted standards of practice for one or more of the following mental health parity conditions:
 - a) Schizophrenia
 - b) Schizoaffective disorder
 - c) Bipolar disorder
 - d) Manic depressive disorders
 - e) Panic disorder
 - f) Obsessive-compulsive disorder
 - g) Pervasive development disorder or autism
 - h) Anorexia Nervosa
 - i) Bulimia Nervosa
 - j) Severe Emotional Disturbances of Children

3. UM Protocols include review of appropriate setting, LOS, practitioner type and indications/contraindications for the requested service. Criteria must be objective, measurable, based on sound clinical evidence, and the individual needs of the members and characteristics of the local delivery system.

4. The criteria hierarchy for MemorialCare Select Health Plan commercial membership
 - a) Federal or State Mandate
 - b) National and local coverage determinations
 - c) Standardized Criteria (MCG)
 - d) Medical Group Criteria or Guidelines
 - (1) National Medical Reviews, Inc.
 - e) Resources including peer reviewed journals and published resources.
 - f) If none, professional judgement or case discussion is used.

- g) Additional criteria may include
 - (1) American Psychiatry Association
 - (2) DSMIV-TR and DSMV
 - (3) ASAM-American Society of Addiction Medicine

- 5. The following factors will be considered when applying criteria to the given individual:
 - a) Age
 - b) Comorbidities
 - c) Complications
 - d) Progress of treatment
 - e) Psychosocial situation,
 - f) Home environment, when applicable

- 6. MemorialCare Select Health Plan and its delegated medical groups also consider available services in the local delivery system and the ability to meet a member's specific health care need when making UM decisions. This could include
 - a) Availability of inpatient outpatient and transitional facilities.
 - b) Availability of outpatient services in lieu of inpatient services such as surgery centers vs. inpatient surgery.
 - c) Availability of highly specialized services, such as transplant facilities or cancer centers.
 - d) Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge.
 - e) Local hospitals' ability to provide all recommended services within the estimated length of stay.

- 7. Standardized criteria at a minimum are:
 - a) In accordance with generally accepted standards of medical practice
 - b) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease
 - c) Not primarily for the convenience of the covered individual, physician or health care provider
 - d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

- 8. MemorialCare Select Health Plan gives practitioners with clinical expertise in the area being reviewed, the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria.

9. Consistency in Applying Criteria

At least annually, MemorialCare Select Health Plan evaluates the consistency with which health care professionals involved in Utilization Management apply criteria in decision making. Consistency of applying criteria is evaluated in all physician reviewers and on all non-physician reviewers. A minimum of 2 physician reviewer will be included in the study. MemorialCare Select Health Plan acts upon opportunities to improve consistency with corrective action when necessary. This process is performed in collaboration with MemorialCare Select Health Plan's Quality Assurance programs and its delegated provider groups. (CA Health and Safety Code sections 1363.5 (a) (b)), (CA Health and safety Code 1367.01 (b))

10. Dissemination of UM Criteria

- a) MemorialCare Select Health Plan provides written policies procedures and clinical support tools to UM staff as appropriate for their role.
- b) Current MemorialCare Select Health Plan UM policies, procedures, criteria and guidelines used to authorize, modify or deny healthcare services to members, or persons designated by members, are available to practitioners and providers including primary care, specialty, and behavioral health providers at all times via the MemorialCare Select Health Plan website provider portal. Practitioners are notified that the information is available in the MemorialCare Select Health Plan provider handbook and communications to their medical groups. Information is also available by mail, fax or e-mail upon request.
- c) MemorialCare Select Health Plan UM policies, procedures and criteria are available to members and /or member representatives at any time via the MemorialCare Select Health Plan website member portal or by mail upon request.
- d) Utilization Management Policies, procedures and Criteria used to authorize, modify, or deny healthcare services are available to the public upon request, although the plan may choose to only disclose the criteria or guidelines for the specific procedures or conditions requested.
- e) The criteria descriptions are not burdensome for the member, the practitioner or MemorialCare Select Health Plan staff.
- f) MemorialCare Select Health Plan dissemination of UM criteria to requesting members and the public will include the following disclosure notice:
"The materials provided to you are guidelines used by this Provider Group to authorize modify or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual needs and the benefits covered under your contract. "

- g) MemorialCare Select Health Plan keeps a record of disclosure requests and copies of responses to providers, members and the public. (CA Health and Safety Code sections 1363.5 (a)(b))

F. COMMUNICATION SERVICES

1. MemorialCare Select Health Plan provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.
2. Staff is available at least eight hours a day during normal business hours for inbound, collect or toll-free calls regarding UM issues and requests for authorizations. Staff is available to make outbound calls regarding UM inquiries during normal business hours. This includes speaking directly with members, practitioners and vendors as well as fax, e-mail or voice mail communication. (CA Health and safety Code 1367.01 (i))
3. Staff identifies themselves by name, title and organization when initiating or returning calls regarding UM issues.
4. MemorialCare Select Health Plan and its contracted medical groups provide TDD/TTY services with a separate number for communication with the hearing impaired.
5. For all members who request language services, the organization provides services, free of charge, in the requested language through qualified bilingual staff or an interpreter service.
6. Nurse Case Managers are available to triage inbound calls related to specific UM cases, for example inquiries regarding complex cases or decisions. Medical Directors and the UM Director are available when needed.
7. Physician reviewers are available by telephone to physicians to request authorization for health care services and discuss determinations.
8. MemorialCare Select Health Plan provides the following information to practitioners and members through provider manuals, member handbooks and Identification cards.
 - a) A toll free number or available staff who accept collect calls regarding UM issues during normal business hours
 - b) Access to staff for callers with questions about the UM process.
 - c) For calls after business hours and when callers receive a message, the following information is provided;
 - (1) Instructions on how to get specific information regarding a request

- (2) Instructions for faxing or leaving a voicemail message outside of business hours that prompt members and practitioners to provide contact information for responses by the UM staff on the next business day.
- (3) Instructions on how out-of-area callers can obtain information

G. REFERRAL AND AUTHORIZATION PROCESS

1. UM Referral Procedure

- a) MemorialCare Select Health Plan and its delegated medical groups have implemented a tracking system for all UM Referrals for documentation, identification, communication and monitoring timeliness standards.
- b) All referrals will be evaluated and authorized by a person with a defined level of responsibility, for clinical and non-clinical, based on the necessary protocols and within the parameters of the requested service.
- c) Qualified appropriately licensed health care professionals will supervise all medically necessary decisions with LVNs as the minimal level of training and licensure allowed to supervise. Non licensed personnel may have the authority to approve using specific approval criteria and not making clinical judgements, but they may not deny. Benefit clarifications do not require a licensed health care professional.
- d) Staff members who are not qualified health professionals may collect data for pre-authorization and concurrent review under the supervision of appropriate licensed health care professionals.
- e) All denial decisions based on medical necessity will be reviewed by a physician, pharmacist, or licensed behavioral health practitioner, as appropriate
- f) Only California licensed physicians who are competent to evaluate specific clinical issues related to requested health care services, may make decisions to deny or modify requests for services based on medical necessity (CA Health and Safety Code sections 1367(e) and (g))
- g) For behavioral health services, MemorialCare Select Health Plan requires involvement of a psychiatrist or other licensed mental health professional in decisions to deny or modify mental health services.
- h) Board certified physicians from appropriate specialty areas will be utilized to assist in making determinations of medical necessity
- i) Medical necessity determinations include:
 - (1) Decisions about covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits.
 - (2) Decisions about pre-existing conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.

- (3) Decisions about care or services whose coverage depends on specific circumstances
- (4) Decisions about dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
- (5) Out of network services that are only covered in clinically appropriate situations
- (6) Pharmacy-related medical necessity denials include step-therapy or prior authorization cases. It does not include denials based on benefits that are specifically excluded from the benefit plan, even when the member requests coverage based on medical necessity
- (7) Experimental or investigational procedures: A medical necessity review is required unless the requested service/procedure is specifically listed as an exclusion of the member's benefit plan. (NCQA UM 1, 2018)
- j) Benefit determinations are decisions on requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.
- k) If the member (or the member's authorized representative) does not follow MemorialCare Select Health Plan or its delegates filing procedures for requesting preservice or urgent concurrent services, MemorialCare Select Health Plan or delegates notifies the practitioner or member of the failure and informs them of the proper procedure to follow when requesting services.
 - (1) For urgent preservice and concurrent decisions, the practitioner or member is notified within 24 hours of receiving the request for services. Notification may be oral, unless the practitioner or member requests written notification.
 - (2) For non-urgent preservice decisions, the practitioner or member is notified within 5 calendar days of receiving the request for service. (NCQA UM 5, 2018)

2. UM Referral Process Timeliness

MemorialCare Select Health Plan and its delegated medical groups follow the current Commercial ICE Timeliness Standards for commercial membership. (CA Health and Safety Code sections 1367.01 (h) (1) and (2))

3. Provider Referral Process

- a) Providers are responsible for verifying eligibility and ensuring that MemorialCare Select Health Plan's UM Department has conducted pre-service reviews for elective non-emergency

and scheduled services before rendering the services.

Preservice review is required for elective inpatient admissions, outpatient surgeries, and diagnostic tests or treatments. Pre-service review ensures that services are based on medical necessity, are a covered benefit, and are provided by the appropriate Providers. It is the provider's responsibility to submit all documentation needed for pre-service referral requests.

- b) Providers can request pre-service review and report medical admission, by calling the UM Department at (855) 367-7747, Fax: (562) 933 – 1891 or visit www.SeasideHealthPlan.org Provider Web Portal.
- c) Services requiring pre-service review include, but are not limited to:
 - (1) Elective Inpatient hospital care
 - (2) Selected surgical procedures (performed in an outpatient or ambulatory surgical center)
 - (3) Selected durable medical equipment (DME)
 - (4) Formula
 - (5) Home health care
 - (6) Speech therapy
 - (7) Sensory integration therapy
 - (8) All infusion therapies
 - (9) Selected MRIs and CT scans
 - (10) Reconstructive procedure
 - (11) Cardiac and pulmonary rehabilitation
 - (12) Transplants
 - (13) Hospice
 - (14) Skilled nursing facilities
 - (15) Out-of-network specialist referrals
 - (16) Out-of-network services

4. Direct Access

a) Reproductive Health Care Services

Members are not required to receive a referral or authorization prior to obtaining care for reproductive and health care services within the MemorialCare Select Health Plan network including:

- (1) Annual Women's OB/GYN Exam & Pre-Natal Care
- (2) Family Planning
- (3) Sexually Transmitted Infections
- (4) Family Planning Services including outpatient abortion

- (5) HIV Testing and Counseling (AB-1954 Health care coverage)
- b) MemorialCare Select Health Plan ensures the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be available within the provider network and Members are informed of the availability of these services in the Member Rights and Responsibility document. Minors do not need parental consent to access these services:
- (1) Sexual assault, including rape diagnosis, treatment and collection of medical evidence
 - (2) Drug or alcohol abuse for children 12 years of age or older
 - (3) Prevention or treatment of pregnancy (except sterilization)
 - (4) Family planning services, including the right to receive Birth control
 - (5) Infectious, contagious, communicable, and sexually transmitted diseases (STDs) for diagnosis and treatment in children 12 years of age or older
 - (6) Abortion services (without parental consent or court permission)
 - (7) HIV Testing and counseling for children ages 12 and older
 - (8) Outpatient behavioral health care for children 12 years of age or older who, in the opinion of the attending provider are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse
 - (9) General medical, psychiatric or dental care in the following conditions:
 - (a) The minor is age 15 or older
 - (b) The minor is living separate or apart from his parents or guardian, whether with or without consent of a parent or guardian and regardless of the duration of the separate residence
 - (c) The minor is managing his or her own financial affairs regardless of the source of the minor's income, of he or she is emancipated, he or she may consent to medical, dental and psychiatric care.

5. Direct Referrals

MemorialCare Select Health Plan Primary Care Physicians may refer members directly to multiple specialty services within network without prior review and authorization by MemorialCare Select Health Plan UM. Visits are limited to one (1) consultation and require completion of a Direct Referral Authorization Form. Information regarding these services is available in the MemorialCare Select Health Plan Provider Manual, the Provider Web Portal and by calling MemorialCare Select Health Plan UM at (855) 367-7747. Subsequent visits and related services require prior authorization.

6. Non-contracted or Unusual Specialty Services Provider Referrals

In order to ensure access to appropriate care, MemorialCare Select Health Plan approves referrals to non-contracted providers or unusual specialty services based on benefits and medical necessity when no similar or same contracted specialist and/or provider are within the MemorialCare Select Health Plan's network. If MemorialCare Select Health Plan approves a member to go out of network because it is unable to provide a necessary and covered service in-network, MemorialCare Select Health Plan coordinates payment with the out-of-network practitioner and ensures that the cost to the member is no greater than it would be if the service was furnished in-network.

7. Classification of UM requests

MemorialCare Select Health Plan uses the guidelines below to classify UM cases.

- a) Urgent request: Requests for medical care or services where application of the time frame for making routine or non-life threatening care determinations:
 - (1) Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
 - (2) In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

- b) Concurrent request: A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

- c) Non-urgent request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.
- d) Pre-service request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.
- e) Post service request: A request for coverage of medical care or services that have been received (e.g., retrospective review).

8. Urgent Pre-Service Requests

- a) Decisions to approve, modify or deny, based on medical necessity, are made in a timely fashion as appropriate for the nature of the member's condition, not to exceed 72 hours of receipt of the request.
- b) Practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision, not to exceed 72 hours of receipt of request.
- c) Member is notified of approvals within 72 hours of receipt of the request.
- d) Practitioner is sent written or electronic notification of denial decisions within 72 hours of receipt of the request.
- e) Member is sent written or electronic notification of denial decisions within 72 hours of receipt of the request.
- f) If oral notification of a denial decision is given to practitioner and member

within 72 hours of receipt of the request, written or elect electronic notification must be given no later than 3 calendar days after the initial verbal notification. Staff must record the date and time of the notification and the staff member who spoke with the practitioner or member. A voicemail is not an acceptable form of oral notification. (NCQA UM 5, 2018)

9. Urgent Pre-Service – Additional Information Required

- a) Practitioner and Member are notified within 24 hours of receipt of the request.
- b) Practitioner and member are provided 48 hours for submission of requested information.

- c) If requested information is received, complete or not, decision is made within 48 hours of receipt of additional information.
- d) If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours.
- e) If additional information is received or incomplete, practitioner is given

initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision, not to exceed 48 hours of receipt of the requested information.

- f) If additional information is received or incomplete, member is notified of approvals within 48 hours after receipt of the requested information. Notification may be verbal, electronic or written.
- g) If information is not received, practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner and member to supply the information.
- h) If information is not received, member is given verbal, electronic or written notification of approval decisions within 48 hours after the timeframe given to the practitioner and member to supply the information.
- i) If additional information is received or incomplete, practitioner and member are sent written or electronic notification of denial decisions within 48 hours after receipt of the requested information.
- j) If additional information is not received, practitioner and member are sent written or electronic notification of denial decisions within 48 hours after the timeframe given to the practitioner and member to supply the information.
- k) If verbal notification of denial decision is given, written or electronic notification to practitioner and member must be given no later than 3 calendar days after the initial verbal notification.

10. Non-Urgent Pre-Service Requests

- a) Decisions to approve, modify or deny, based on medical necessity, are made in a timely fashion appropriate for the nature of the member's condition, but not to exceed 5 business days of receipt of the request.

- b) Practitioner is given initial notification of approval, modification or denial via telephone, fax, e-mail, or online within 24 hours of making decision.
- c) Member is notified of approval within 2 business days of the decision. Notification may be verbal, electronic or written.
- d) Practitioner is sent written or electronic notification of denial decision within 2 business days of making the decision.
- e) Member is sent written or electronic notification of denial decision within 2 business days of making the decision.

11. Non-Urgent Pre-service – Additional Information or Expert Review Required

- a) Practitioner and Member are notified within 5 business days of receipt of the request.
- b) Member and practitioner are provided at least 45 calendar days for submission of requested information.
- c) If a consultation by an expert reviewer is required, upon expiration of the 5 business days or as soon as it is known that the 5 business day timeframe will not be met, whichever occurs first, the practitioner and member must be notified of the type of expert reviewer required and the anticipated date on which decision will be rendered (no more than 15 calendar days from the date of the pended notification).
- d) If requested information is received, complete or not, decisions are made within 5 business days of receipt of additional information.
- e) If no information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 5 business days.
- f) If a consultation by an expert reviewer is required, decision is made within 15 calendar days from the date of the pended notification.
- g) Practitioner is given initial notification of approvals and denials via telephone, fax, e-mail, or online within 24 hours of making decision.
- h) Member is notified of approvals within 2 business days of making the decision. Notification may be verbal, electronic or written.
- i) Practitioner and Member are sent written or electronic notification of denial decisions within 2 business days of making the decision.

- j) If a consultation by an expert reviewer is required, practitioner and member are given written/electronic notification of denial decision within 2 business days of making the decision.
12. Urgent Concurrent Requests (e.g., inpatient, ongoing ambulatory services)
- a) Urgent concurrent requests involve both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. (Exceptions: When request is not received at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to the Urgent Pre-Service category. When the request to extend a course of treatment beyond the period of time or number of treatments previously approved does not involve urgent care, default to the Non-Urgent Pre-Service category.)
 - b) Care cannot be discontinued until the member's treating practitioner has been notified of the decision and a care plan has been agreed to by the treating practitioner that is appropriate for the medical needs of the member. (CA Health and Safety Code 1367.01(h)(3))
 - c) Decision is made within 24 hours of receiving request.
 - d) Practitioner is given initial notification of approval and denial decisions via telephone, fax, e-mail, or online within 24 hours of receiving request.
 - e) Member is notified of approvals within 24 hours of receipt of request. Notification may be verbal, electronic or written. (Hospitalist programs are not required to provide notifications of approvals or denials.)
 - f) Practitioner is sent written or electronic notification of denial decisions within 24 hours of receipt of request.
 - g) Member is sent written or electronic notification of denial decisions within 24 hours of receipt of the request. If verbal notification of denial decision is given within 24 hours of receipt of the request, then written or electronic notification to practitioner and member must be given no later than 3 calendar days after the initial verbal notification. Staff must record the date and time of notification and the name of the staff member who spoke with the practitioner or the member. A voicemail is not an acceptable form of oral notification. (NCQA UM 5, 2018)

- h) For urgent concurrent denials, MemorialCare Select Health Plan or delegates may inform the hospital Utilization Review (UR) department staff of the decision, with the understanding that staff will inform the attending/treating practitioner. (NCQA UM 5, 2018)

13. Post-Service Requests

- a) Decision is made within 30 calendar days of receipt of the request.
- b) Practitioner is sent written or electronic notification of denial decision within 30 calendar days of receipt of request.
- c) Member is sent written or electronic notification of denial decision within 30 calendar days of receipt of request.

14. Post-Service – Additional Information or Expert Review Required

- a) Practitioner and Member are notified within 30 calendar days of receipt of the request.
- b) Practitioner and member are provided at least 45 calendar days for submission of requested information.
- c) If a consultation by an expert reviewer is required, upon expiration of the 30 calendar days or as soon as it is known that the 30 calendar day timeframe will not be met, whichever occurs first, the practitioner and member must be notified of the type of expert reviewer required and the anticipated date on which a decision will be rendered (decision will be rendered no more than 15 calendar days from the date of the pend notification).
- d) If additional information is received, complete or not, decisions are made within 15 calendar days of receipt of requested information.
- e) If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information available within an additional 15 calendar days.
- f) If a consultation by an expert reviewer is required, decision is made within 15 calendar days from the date of the pended notification to the practitioner and member.
- g) If additional information was received or incomplete, practitioner and member are sent written or electronic notification of denial decisions within 15 calendar days of receipt of requested information.

- h) If no additional information is received, practitioner and member are sent written or electronic notification of denial decisions within 15 calendar days after the timeframe given to the practitioner and member to supply the information.
- i) If a consultation by an expert reviewer was required, practitioner and member are given written or electronic notification of denial decision within 15 calendar days from the date of the pended notification.

15. Information Necessary for the UM Process

When making a determination of coverage based on medical necessity for medical and Behavioral Health authorization requests, MemorialCare Select Health Plan and its contracted medical groups will obtain and document in the file, relevant clinical information (only the information that is reasonably necessary to make a determination) and consult with the treating physician, as necessary.

Clinical information may include, but is not limited to: a)
Office and hospital records.

- b) A history of the presenting problem.
- c) Physical exam results.
- d) Diagnostic testing results.
- e) Treatment plans and progress notes.
- f) Patient psychosocial history.
- g) Information on consultations with the treating practitioner.
- h) Evaluations from other health care practitioners and providers.
- i) Operative and pathological reports.
- j) Rehabilitation evaluations.
- k) A printed copy of criteria related to the request.
- l) Information regarding benefits for services or procedures.
- m) Information regarding the local delivery system.
- n) Patient characteristics and information.
- o) Information from family members.

Referral review and decision processes will be based on eligibility, plan benefits, necessity using the hierarchy as defined in section E.

16. Referral Cancellation

MemorialCare Select Health Plan tracks, monitors, reviews and reports all decisions to cancel a utilization request in order to avoid any interruption in patient care, delay in patient care, or resulting underutilization.

Requesting practitioners are notified of any cancelled request either verbally or by written communication.

Cancelled referral requests are tracked and monitored by the UMC committee

Examples of cancelled requests may include the following

- a) Already approved authorization request in the system
- b) Expired referral request
- c) The member terminated with MemorialCare Select Health Plan
- d) Duplicate requests not received on the same day
- e) Addition or change in diagnosis or procedure codes
- f) Service is part of the global period

H. BEHAVIORAL HEALTHCARE TRIAGE AND REFERRAL

1. MemorialCare Select Health Plan maintains responsibility for the Utilization Review determinations for Behavioral Healthcare services. The criteria and guidelines used to authorize, modify or deny health care services are
 - a) Developed with involvement from actively practicing health care providers
 - b) Consistent with sound clinical principles and processes
 - c) Evaluated, and updated if necessary, at least annually
2. MemorialCare Select Health Plan maintains telephone access for providers to request authorization for health care services.
3. MemorialCare Select Health Plan maintains procedures that are adopted for initial referrals to mental health providers. Protocols address the urgency of the member's clinical circumstances and define the appropriate care settings and treatment resources that are to be used for both mental health and substance abuse cases. These include:
 - a) Member access to a mental health delivery system through a centralized triage and referral system. Protocols for mental health triage and referral address the level of urgency and appropriate level of care relative to the member's mental status and level of functioning (28 CCR 1300.67) (28 CCR 1300.74)
 - b) Established standards and goals for the timeliness of response to its triage and referral telephone lines and measures performance against those standards. If MemorialCare Select does not meet its goals it takes an appropriate corrective action and re-measures results after corrective action has been implemented.
 - c) MemorialCare Select ensures that only qualified licensed clinical staff members make decisions about the type and level of care to which members are referred.

- d) A licensed psychiatrist or an appropriately licensed Doctoral-level clinical psychologist experienced in clinical risk management will oversee triage and referral decisions
 - e) MemorialCare Select ensures that prior authorization is not required for the provision of emergency services and care to a patient with a psychiatric emergency
 - f) Behavioral Health triage and referral decisions are made according to protocols for mental health and substance abuse that define the urgency and appropriate setting of care
4. MemorialCare Select Health Plan maintains a toll -free telephone intake system for members, which is staffed by trained personnel who are either individually licensed psychiatrist or a licensed doctoral-level clinical psychologist, or supervised by a licensed master's-level mental health professional with five years of post-master's clinical experience, and which provides for appropriate crisis intervention and initial referrals to mental health providers. (CA Health and safety Code 1367.01 (i))
 5. MemorialCare Select Health Plan provides a 24 hour crisis line where crisis line staff assesses the level of care, urgency or response or type of practitioner need prior to arranging an appropriate Behavioral Health appointment
 6. Triage and referral decisions requiring clinical judgment are made by a licensed Behavioral Health Care practitioner with appropriate qualified experience pertaining to their specialty
 7. Triage and referral staff are supervised by a licensed Behavioral Health Care practitioner with a minimum of a Master's degree and 5 years of post-masters clinical experience
 8. MemorialCare Select Health Plan provides as part of the quality assurance program a process to review the referral process for mental health services that includes evaluations of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms, to communicate actions and results to the appropriate employees and contracted providers, and provisions for evaluation of any corrective action plan and measurements of performance.
 9. At least annually, MemorialCare Select Health Plan gathers information from members and practitioners regarding their satisfaction with the Behavioral Health UM process and address identified sources of dissatisfaction. (NCQA UM 12, 2018)

I. BEHAVIORAL HEALTH AUTHORIZATION PROCESS

1. Authorization requests for Behavioral Health are reviewed to determine the type of authorization required. Including but not limited to:

- a) Demographics
 - b) Type of provider requested, i.e. Therapist, Psychologist, or Psychiatrist
 - c) Level of care
2. Behavioral Health authorization requests are auto approved for an initial evaluation followed by six (6) visits.
 3. After completion of the 6 (six) visits, the member's plan of care is evaluated by the Medical Director of Windstone along with SHPs Chief Medical Officer to determine appropriateness. During that evaluation additional treatments and/or sessions are approved based on the plan of care and recommendations of the mental health provider.

J. NOTIFICATIONS TO MEMBERS AND PROVIDERS

1. Decisions to approve, modify or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to members, are communicated to the requesting provider within 24 hours of the decision.
2. Except for concurrent review decisions pertaining to care that is underway, which are communicated to the member's treating provider with 24 hours, decisions resulting in the denial, delay or modification of all or part of the requested health care service are communicated to the member in writing within 2 business days of the decision. In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the Plan's decision and a Care Plan has been agreed upon by the treating provider that is appropriate for the medical needs of the member.
3. Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to members must specify the specific health care service approved.
4. Denial notifications
Notification of denial of services from MemorialCare Select Health Plan must clearly document the reasons for each denial or modification. Members and practitioners must receive sufficient information to understand and make a choice regarding their decision to appeal a denial of care or coverage.
Denial notifications must include the following
 - a) A clear and concise explanation of the reasons for the decision to deny, delay or modify health care services.
 - b) Written communications to physicians/healthcare practitioners regarding denial, delay or modification of a request must include an opportunity to discuss any UM denial decision with a physician reviewer and include the

name and direct phone number of the denying physician in order to allow the requesting provider to easily contact him or her.

- c) Medical necessity denials must include the specific clinical reason for the denial and an easy to understand summary of the utilization management criteria on which the denial decision was based in relation to the member's medical condition.
- d) Benefit denials must include a reference to the specific benefit provision that excludes the health care service requested
- e) Denial letters must state that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request
- f) Denial notifications must instruct the member to contact the requesting provider for an explanation of diagnosis and treatment codes
- g) Denial letters must include standard and expedited appeal rights and process including
 - (1) An explanation of the appeal and grievance process for MemorialCare Select Health Plan and contact information for filing.
 - (2) Right to submit written comments, documents or other relevant appeal information
 - (3) Right to member representation, members may be represented by anyone they choose, including an attorney.
 - (4) Timeframes for appeal submittal and resolution
 - (5) A description of the expedited appeal process for urgent preservice or urgent concurrent denials
 - (6) Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
- h) The denial letter must include instructions on how the member may request an independent medical review in cases where the member believes that healthcare services have been improperly denied, modified, or delayed by MemorialCare Select Health Plan or one of its delegated medical groups.
- i) Members are provided the Independent Medical Review Application/ Complaint Form (DMHC 20-224), effective September 1, 2018. The form is available in 15 threshold languages. (APL 18-013 (HC))
- j) Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsman, if applicable.
- k) Names of copied practitioners

5. Pended Referral Notifications

If decisions to approve modify or deny a referral cannot be made within 5 business days, notification is sent to the practitioner and to the member. Pended referrals are tracked to ensure that decisions are made timely

The notification includes the following;

- a) The reason for pending (e.g. information was requested but not received, consultation by an expert reviewer is required, or additional examinations or tests are required.
- b) Specific information needed
- c) Time frame for submission of additional information
- d) Expected date of decision
- e) Type of expert reviewer required, if applicable
- f) Physician reviewers name and direct phone number
- g) Offer of translation to the member

K. STANDING REFERRALS

1. MemorialCare Select Health Plan and its delegated medical groups coordinate standing referrals for members who need continuing care from a specialist or who require specialized care over a prolonged period of time for the purpose of having the specialist coordinate the member's health care. These members may have life-threatening, degenerative or disabling conditions that require a specialist or specialty care center that has expertise in treating the condition or the disease, including HIV/AIDS. (1374.16)
2. The Primary Care Physician, specialist(s) and member submit a collaborative treatment plan to MemorialCare Select Health Plan for review by the Medical Director. Some treatment plans may limit the number of visits to the specialist, limit the period of time the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the member.
3. MemorialCare Select Health Plan will make the determination within three (3) business days of the date a request for a standing referral is made and all appropriate information necessary to make the determination is provided.
4. When approved, the referral will be provided within four (4) business days of the date the authorization request is submitted to MemorialCare Select Health Plan or its delegate. Services shall be authorized as medically necessary for the proposed treatment, of a duration not to exceed one year at a time, utilizing established criteria and consistent with the member's benefit plan.
5. Approval letters for all referral requests specify the specific services approved.
6. Denial letters for all referral requests provide a clear and concise explanation of the reasons for the denial; specify the clinical reasons for the decision to deny, delay or modify services; provide the name of and a direct phone number for the physician responsible for the denial, delay or modification; and provide the member with

information regarding filing a grievance or appeal with MemorialCare Select Health Plan and how to request an independent Medical Review (IMR).

7. MemorialCare Select Health Plan makes referrals to specialists or specialty care centers that have demonstrated sufficient expertise in treating the condition or disease. Specifically, when authorizing a standing referral for a condition requiring care by a Physician with a specialized knowledge of HIV medicine, the Plan refers the enrollee to an HIV/AIDS specialist. (CA H & S 1374.16 (a), (b), (e)) (28 CCR 1300.74.16 (e) (f))
8. Specialists and specialty care centers are validated to assure accreditation or designation as having special expertise in treating the condition or disease using MemorialCare Select Health Plan Credentialing protocols. Lists of specialists, including HIV/AIDS 9 (as defined by 28 CCR 1300.74.16) are updated at least yearly and are kept in accessible files as necessary. HIV/AIDS specialists are identified in the MemorialCare Select Health Plan Provide Directory and updated annually. Interim changes or notifications are provided to the UM Department by Credentialing. Listings of specialists and specialty care centers, including HIV/AIDS specialist are also available via the MemorialCare Select Health Plan website
9. MemorialCare Select Health Plan is not required to provide standing referrals to non-contracted specialists or specialty care centers unless there is not a specialist within the network that is appropriate to provide treatment for the member as determined by the Primary Care Physician and the Medical Director. The Primary Care Physician may request authorization for an out of network specialist if an appropriate specialist for the member's condition is not available within network. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care with a specialized knowledge of HIV medicine, MemorialCare Select Health Plan will refer the member to an HIV/Aids specialist who meets California Health and Safety Code Criteria. (28 CCR 1300.74.16)
10. When a specialist or specialty care center has been approved to coordinate the enrollee's health care, MemorialCare Select Health Plan approves the specialist to provide health care services within the specialist's area of expertise and training in the same manner as it approves the enrollee's Primary Care Physician's services, subject to the terms of the treatment plan. (CA H & S 1374.16 (b))

L. RECONSTRUCTIVE AND COSMETIC SURGERY

1. MemorialCare Select Health Plan reviews referral requests for prior authorization of reconstructive and cosmetic procedures through the UM Referral and Authorization Process.

2. MemorialCare Select Health Plan covers reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease that is necessary to either improve function or create a normal appearance to the extent possible (CA Health and Safety Code § 1367.63)
3. Only a licensed physician competent to evaluate the specific clinical issues involved in the care requested may deny initial requests for authorization of coverage. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual, competent to evaluate the specific clinical issues involved in the care requested.
4. Reconstructive surgery shall include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.
5. In interpreting the definition of reconstructive surgery, MemorialCare Select Health Plan may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following
 - a) Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for the enrollee
 - b) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only a minimal improvement in the appearance of the enrollee
 - c) Denial of payment for procedures performed without prior authorization.
6. Cosmetic surgery meaning surgery that is performed to alter or reshape normal structures of the body in order to improve appearance is not covered.

M. EMERGENCY AND POST STABILIZATION CARE

1. Emergency Services are covered if an authorized representative acting on behalf of MemorialCare Select Health Plan has authorized the provision of emergency services
2. MemorialCare Select Health Plan will authorize continued care for members who have received emergency services and care is stabilized, but the treating practitioner believes that the member may not be discharged safely
3. Emergency services are covered to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

- a) For purposes of applying this standard, a prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency treatment
 - b) A prudent layperson is considered to have acted “reasonably “if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.
4. Prior authorization for emergent medical conditions is not required regardless to whether the provider has a contract or when:
 - a) There is an imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function and active labor or emergency labor and delivery.
 - b) A delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.
 5. MemorialCare Select Health Plan contracts with mental health practitioners, programs, and facilities to provide services to members that require urgent or emergent mental health care. These services include crisis intervention and stabilization as well as psychiatric inpatient hospital services within the service area 24 hours-a-day, 7 days-a-week. MemorialCare Select Health Plan pays for all involuntary psychiatric (5150) hospitalizations. MemorialCare Select Health Plan ensures that prior authorization is not required for the provision of emergency services and care to a patient with a psychiatric emergency
 6. ER criteria are utilized and denial decisions will take into consideration presenting symptoms and not be based solely on discharge diagnosed.
 7. Requests will not be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the claimant (e.g. the member is unconscious and in need of immediate care at the time medical treatment is required)
 8. MemorialCare Select Health Plan requires prior authorization for post-stabilization care and provides 24 hour access for patients and providers, including non-contracting hospitals, to obtain timely authorization for medically necessary post stabilization care through its publicized 24 hour, toll- free Member Service line.
 9. If a member receiving emergency care is stabilized, but the health care provider believes that the member requires additional medically necessary health care services and may not be discharged safely, MemorialCare Select Health Plan responds to the hospital’s call for authorization within the first call and makes a determination within 30 minutes of the request. The transferring hospital will not

have to make more than one call before MemorialCare Select Health Plan provides a response.

10. If MemorialCare Select Health Plan does not provide a determination within 30 minutes of the request, it will pay any claims submitted by the provider for the post-stabilization care provided.
11. After discussion with the treating physician, MemorialCare Select Health Plan may choose to arrange a safe transfer of the member to another facility if the member has been stabilized subsequent to an emergency psychiatric or medical condition but the provider believes further medically necessary health care treatment is needed and the member is not safe to discharge. (CA Health and Safety Code 1262.8)
12. If MemorialCare Select Health Plan denies the request for authorization of post-stabilization medical care at the requesting facility and elects to transfer the member to another facility, MemorialCare Select Health Plan or its delegate will effectuate the transfer as soon as possible. MemorialCare Select Health Plan will not transfer a member to a contracting facility unless the provider determines no material deterioration of the member is likely to occur upon transfer. MemorialCare Select Health Plan will pay for all medically necessary health care services provided to the member needed to maintain the member's stabilized condition up to the time that the transfer is effectuated by MemorialCare Select Health Plan.
13. If there is a disagreement between MemorialCare Select Health Plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, MemorialCare Select Health Plan shall assume responsibility for the care of the Member either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient
14. Out of Service Area: Providers are reimbursed for emergency services and care provided to its members in and out of service areas, until the care results in stabilization of the member.
 - a) Out of service area providers are not required to obtain authorization prior to the provision of emergency services and care necessary to stabilize the member's medical condition;
 - b) MemorialCare Select Health Plan does not require pre-authorization and reimburses out of service area providers for emergency services and care provided to its members until the care results in stabilization of the member.
15. MemorialCare Select Health Plan contracts with ambulance services for the area served by MemorialCare Select Health Plan to transport the member to the nearest

24 hour emergency facility with Physician coverage, designated by the health care service Plan. When possible, out-of-area urgent or emergency services are directed to MemorialCare Select Health Plan's service area.

N. HOSPICE AND PALLIATIVE CARE

1. MemorialCare Select Health Plan ensures that Members and their families are fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services.
2. Hospice Services are limited to individuals who have been certified as terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course and who directly or through their representative voluntarily elect to receive such benefits in lieu of other care as specified.
3. Per § 1368.2. KNOX-KEENE ACT, Hospice care at a minimum is equivalent to the hospice care provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act. All hospice services provided by MemorialCare Select Health Plan will be with Medicare certified providers.
4. Palliative Care consists of patient and family-centered-care that optimizes quality of life by anticipating, preventing and treating suffering. MemorialCare Select Health Plan provides a Palliative Care Program that includes, but is not limited to:
 - a) Specialized medical care and emotional and spiritual support for people with serious advanced illnesses
 - b) Relief of symptoms, pain, and stress of serious illness
 - c) Improvement of quality of life for both the member and family
 - d) Appropriate care for any age and for any stage of serious illness, along with curative treatment (Welfare & Institutions Code 14132.75)
5. MemorialCare Select Health Plan utilizes trained, qualified, contracted Palliative Care physicians and providers who support appropriate palliative care based on the setting and needs of the member.
6. MemorialCare Select Health Plan uses multiple resources to identify members who might be eligible and would benefit from the services provided in their Palliative Care Program. These resources include, but are not limited to;
 - a) Referrals from Primary Care Physicians and specialty providers. SHP providers are informed and educated regarding the palliative care benefit in the provider handbook and provider notifications in print and online.
 - b) MemorialCare Select Health Plan Care Managers who may identify appropriate members through care coordination, prior authorization, concurrent review or discharge planning of members with eligible conditions.

- c) Referrals from Case Managers, Social workers or LTSS coordinators at the Primary Plans.
- d) Emergency Room Visits

O. EXPERIMENTAL AND INVESTIGATIONAL SERVICES

1. MemorialCare Select Health Plan does not cover experimental services. MemorialCare Select Health Plan does not cover investigational services except when it is clearly documented that all of the following apply:
 - a) Conventional therapy will not adequately treat the intended member's condition
 - b) Conventional therapy will not prevent progressive disability or premature death
 - c) The provider of the proposed service has a record of safety and success that is equivalent or superior to that of other providers of the investigational service
 - d) The investigational service is the lowest cost item or service that meets the member's medical needs and is less costly than all conventional alternatives
 - e) The service is not being performed as a part of a research study protocol
 - f) There is a reasonable expectation that the investigational service will significantly prolong the member's life or will maintain or restore a range of physical and social function suited to activities of daily living.
2. All investigational services require prior authorization. Payment will not be authorized for investigational services that do not meet the above criteria or for associated inpatient care when a beneficiary needs to be in the hospital primarily because she/he is receiving such non-approved investigational services.
3. Experimental services means those drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans.
4. Investigational services means those drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress but:
 - a) Testing is not complete
 - b) The efficacy and safety of such services in humans subjects is not yet established
 - c) The service is not in wide usage.
5. The determination that a service is experimental or investigational is based on:
 - a) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing

- Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
- b) Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
 - c) Reference to current medical literature.
6. The following five criteria are considered in making a decision:
- a) The device/service must have received final approval from the appropriate regulatory agency (e.g., FDA), and
 - b) Peer-reviewed literature must demonstrate the impact of the service/procedure on health outcomes, and
 - c) The evidence must show that the technology improves health outcomes, and
 - d) The technology must be at least as effective as established technology, and
 - e) The outcomes must be obtainable outside investigational settings

P. CANCER CLINICAL TRIALS

1. MemorialCare Select Health Plan provides coverage for all routine patient care costs for a member diagnosed with cancer and accepted into a phase I, phase II, phase III or phase IV clinical trial for cancer. MemorialCare Select Health Plan will cover routine patient care costs related to the clinical trial if the member's contracted treating physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the member.
2. Routine patient care costs means the costs associated with the provision of health care services, including drugs, items, devices, and services that would normally be covered by MemorialCare Select Health Plan including:
 - a) Health care services typically provided absent a clinical trial.
 - b) Health care services required solely for the provision of the investigational drug, item, device or service
 - c) Health care services required for the clinically appropriate monitoring of the investigational item or service
 - d) Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
 - e) Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.
3. Routine patient care costs would not include the following:
 - a) Drugs or devices that have not been approved by the Federal Food and Drug Administration and that are associated with the clinical trial.

- b) Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses
 - c) Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the member.
 - d) Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage by MemorialCare Select Health Plan.
 - e) Health care services customarily provided by the research sponsors free of charge for any member in the trial.
4. MemorialCare Select Health Plan will provide treatment in a clinical trial that either:
- a) Involves a drug that is exempt under federal regulations from a new drug application
 - b) Is approved by one of the following
 - (1) One of the National Institutes of Health
 - (2) The FDA in the form of an investigational new drug application
 - (3) The United States Department of Defense
 - (4) The United States Veterans' Administration
5. In the case of health care services provided by a participating provider, MemorialCare Select Health Plan will pay the contracted rate. In the case of a non-participating provider, MemorialCare Select Health Plan will pay the same contracted rate it would pay a contracted provider for the same services, less any applicable copayments and deductibles.
6. MemorialCare Select Health Plan may restrict coverage for clinical trials to participating hospitals and physicians in California unless the protocol for the clinical trial is not provided at a California Hospital or by a California physician.
7. Member copayments and deductibles applied to services delivered in a clinical trial shall be the same as those applied to the same services if not delivered in a clinical trial. (§ 1370.6 KNOX-KEENE ACT)

Q. TERMINAL ILLNESS

1. If MemorialCare Select Health Plan denies coverage to a member identified with terminal illness for treatment, services or supplies deemed experimental, as recommended by a participating plan provider, additional steps to the denial process are applied. Terminal illness is defined as an incurable or irreversible condition that has a high probability of causing death within one year or less. The following information will be provided to the member within (5) five business days.

- a) A statement describing the specific medical and scientific reasons for denials
 - b) A description of alternative treatment, services or supplies covered by MemorialCare Select Health Plan, if any.
 - c) A copy of MemorialCare Select Health Plan's grievance procedures as well a copy of the MemorialCare Select Health Plan Terminal Illness Complaint Form. This form provides the member with the opportunity to request a conference as part of MemorialCare Select Health Plan's grievance process.
2. Upon receipt of the Terminal Illness Complaint Form
- a) MemorialCare Select Health Plan provides the member, within 30 calendar days, an opportunity to attend a conference, to review the information provided to the member, conducted by a MemorialCare Select Health Plan representative attending the conference who will have authority to determine the disposition of the complaint.
 - b) The Plan allows attendance, in person, at the conference by a member, a designee of the member, or both, or if the member is a minor or incompetent, the parent, guardian, or conservator of the member, as appropriate.
 - c) The conference is held within 5 business days if the treating participating physician determines, after consultation with MemorialCare Select Health Plan's Chief Medical Officer or designee and based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the Plan, would be materially reduced if not provided at the earliest possible date. (CA Health and safety Code 1368.1)

R. EVALUATION OF NEW TECHNOLOGIES

1. New technologies and new applications of existing technologies are evaluated and approved for coverage when they provide a demonstrable benefit for a particular illness or disease; are scientifically proven to be safe and efficacious; and there is no equally effective or less costly alternative. Emerging and innovative technologies are monitored by MemorialCare Select Health Plan through review of trend reports from technology assessment bodies, government publications, medical journals and information provided by providers and professional societies. A systematic process for evaluating a new technology or new application of an existing technology is proactively initiated when sufficient scientific information is available. Plan developed standards guide the evaluation process to assure appropriate coverage determinations.
2. MemorialCare Select Health Plan's evaluation of new technology and the new application of existing technology for inclusion in its benefit plan include the following
 - a) Medical Procedures
 - b) Behavioral Health procedures

- c) Pharmaceuticals
- d) Devices

3. Issues are also selected for review for new medical policy development through referrals from staff, physicians, provider communities, and members. Priority may be given to the following:
 - a) New diagnostic tests, therapeutic procedures or medical devices for which other good alternatives do not exist
 - b) Medical technologies that may have a safety concern
 - c) Medical technologies that are considered life saving
 - d) Medical technologies that are controversial with respect to their clinical utility
 - e) Medical technologies that have generated a high level of interest
 - f) New information published in the peer-reviewed scientific literature that may change the status of a technology from investigational to medically necessary.
4. The following sources are considered in the review of medical policy for new technology:
 - a) Technology assessments publically published and based on a systematic review of the evidence
 - b) Peer-reviewed publications
 - c) Evidence based clinical practice guidelines developed by national organizations and other recognized authorities, including Hayes, Inc. Technology website and Hayes Reports.
 - d) Generally accepted standards of medical practice
 - e) External practicing physician review
 - f) Government approval status
5. Technology Assessment Process

A core committee of MemorialCare Select Health Plan medical directors and high-level physician specialists, practitioners and/or pharmacists evaluates and recommends coverage for new technologies. Their decisions are based on information provided by professional assessment and policy development organizations, as well as other medical experts.

The technology assessment process is applied to both the development of new medical policies and review of existing policies. In order to determine whether a new medical technology may be considered medically necessary, the research is reviewed against the following criteria. New technology must minimally meet the following guidelines to be approved for coverage:

 - a) Technology must improve health outcomes. The beneficial effects must outweigh any harmful effects on health outcomes. It must improve the length or quality of life or ability to function.

- b) Technology must be as beneficial as any established alternative. It should improve the net health outcome as much, or more than, established alternatives.
- c) Application of technology must be appropriate, in keeping with good medical standards and useful outside of investigational settings.
- d) Technology must meet government approval to market by appropriate regulatory agency as applicable.
- e) Criteria must be supported with information provided by well-conducted investigations published in peer-reviewed journals. The scientific evidence must document conclusions that are based on established medical facts.
- f) Opinions and evaluations of professional organizations, panels or technology assessment bodies are evaluated based on the scientific quality of the supporting evidence.

In addition, the following criteria apply to new diagnostic technologies (e.g. imaging studies, laboratory procedures, and home monitoring devices):

- a) Technical feasibility is demonstrated, including reproducibility and precision. For comparison among studies, a common standardized protocol for the new diagnostic technology is established
- b) For accurate interpretation of study results, sensitivities, specificities, and positive and negative predictive values compared to standards are established
- c) The clinical utility of a diagnostic technique, i.e. how the results of the study can be used to benefit patient management, is established. The clinical utility of both positive and negative tests must be established. (NCQA UM 10:, 2018)

S. MENTAL HEALTH PARITY

1. MemorialCare Select Health Plan provides hospital, medical and surgical coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions, including but not limited to:
 - a) Maximum lifetime benefits
 - b) Copayments
 - c) Individual and family deductibles
2. MemorialCare Select Health Plan's referral system provides members with timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of mental health conditions and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician.

3. MemorialCare Select Health Plan maintains a telephone number that a member may call during normal business hours to obtain information about benefits, providers, coverage and other relevant information concerning an enrollee's mental health services. This number is available on the member's identification card with information saying this number may be used for information regarding mental health services and coverage.
4. MemorialCare Select Health Plan monitors the continuity and coordination of care its members receive for mental health services and when necessary, takes action in order to ensure members receive care in a manner consistent with professionally recognized evidence-based standards of practice across the network.
5. MemorialCare Select Health Plan monitors, as often as necessary, but not less than once every year, the collaboration between medical and mental health providers including, but not limited to:
 - a) Exchange of information
 - b) Appropriate diagnosis, treatment and referral
 - c) Access to treatment and follow-up for members with co-existing medical and mental health disorders (CA Health and Safety Code 1374.72)

IV. DOCUMENTATION

All encounters for MemorialCare Select Health Plan, its delegated medical groups and contracted entities whether verbal, written or electronic are documented confidentially based on department protocols in the appropriate system with all relevant information in a timely and concise manner.

A. UMC COMMITTEE MINUTES WILL:

1. Be documented, contemporaneous, clear, accurate, dated, signed by the Chief Medical Officer by the date of the next meeting, current and available for review.
2. Indicate attendees
3. De-identify members/practitioners and providers
4. Include attachment of applicable reviewed items
5. Be stored in a confidential area with authorized staff access only
6. Reflect the Utilization Management process i.e. committee decisions, action plan implementation and evaluation/follow-up
7. Contain results/reports of clinical data/statistics and audits/studies/findings
8. Document Inpatient and outpatient review findings
9. Reflect review of practitioner UM statistics, denials and appeals
10. Provide evidence feedback to, ongoing education of and communication with practitioners and/or members by Committee

11. Contain Utilization Management information relevant to any Quality Management issue identified with reports to Quality Council and any applicable subcommittees.
12. Provide review of subcommittee reports (as applicable)
13. Minutes will reflect continuity of issues from meeting to meeting, problem identification, action plan, follow up and re-evaluation.
14. All members must sign a confidentiality statement

B. UM REFERRAL DOCUMENTATION

1. Denials will include clinical information documented on the authorization request form or on attached medical record copies. Determinations related to benefit limitations/exclusions must evidence consultation with MemorialCare Select Health Plan.
2. All UM Referral requests, decisions, notifications and all pertinent related actions will be documented in the applicable UM file.
3. Practitioner notification of the availability of physician and behavioral health reviewers to discuss decisions will ensure that practitioners receive information sufficient to understand and discuss with the member about appealing a decision to deny care or coverage.
4. Communications regarding decisions to approve requests by practitioners will specify the specific health care service approved.
5. For all telephonic notifications, practitioner/provider/member name, the time, date, and signature of the person who spoke with the practitioner/provider/member will be documented.

C. DOCUMENTATION OF APPROPRIATE REVIEWER

1. A handwritten signature, handwritten initials or unique electronic identifier on the letter of denial or on the notation of denial in the file.
2. A signed or initialed note from a UM staff person who attributes the denial decision to the specific professional who reviewed and decided the case. Decisions must be made in accordance with state licensure requirements, if applicable.
3. Medical denial files contain documentation that a physician reviewed all denial decisions for medical services based on medical necessity
4. Pharmaceutical denial files contain documentation that a physician or a pharmacist reviewed all denial decisions for pharmaceutical services based on medical necessity.
5. Dental denial files contain documentation that a physician or dentist reviewed all denial decisions for dental procedures made based on medical necessity.
6. Chiropractic denial files contain documentation that a physician or chiropractor reviewed all denial decisions for chiropractic services based on medical necessity.

7. Physical therapy denial files contain documentation that a physician or licensed physical therapist reviewed all denial decisions for physical therapy services based on medical necessity.

V. REFERENCES/AUTHORITY

- A. 28 CCR 1300.67, California Code of Regulations
- B. 28 CCR 1300.74, California Code of Regulations
- C. CA Health and Safety Code §1262.8.
- D. CA Health and Safety Code §1367
- E. CA Health and Safety Code §1368.1 F. CA Health and Safety Code §1374.16.
- G. CA Health and Safety Code § 1374.72
- H. CA Health and Safety Code § 1363.5
- I. APL 18-013 (AC), Independent Medical Review (IMR)/Complaint Form (DMHC 20-224)
- J. Knox Keene Act § 1370.6
- K. NCQA UM 10: Evaluation of New Technology. (2018).
- L. NCQA UM 12: Triage and Referral for Behavioral Healthcare. (2018).
- M. NCQA UM 1: Utilization Program Structure. (2018)
- N. NCQA UM 5: Timeliness of UM Decisions (2018)
- O. NCQA Standards for Utilization Management (2018)
- P. AB 1954 Health Care Coverage: Reproductive Health Care Service

VI. ATTACHMENT

1. ICE Utilization Management Timeliness Standards (Commercial HMO - California)