Seaside Health Plan Policies and Procedures	**Effective Date:** May 17, 2013 **Note: For origination date see last page**
SUBJECT: UTILIZATION MANAGEMENT PROGRAM	**Approval Signature:** Barry Smith, MD Chief Medical Officer
Manual: Utilization Management **Policy/Procedure:** UM-100 **Section:** UM Program	**Sponsor Signature:** Kimberly Ward, RN Director Utilization Management
☒ **COMMERCIAL** ☒ **HEALTHY FAMILIES** ☒ **MEDI-CAL** ☒**MEDICARE**	

AUTHORITY
CA Health and Safety Code section 1367.01(b)
Welfare & Institutions Code Section 14185

POLICY
Seaside Utilization Management (UM) Program assures the delivery of medically necessary, optimally achievable, quality patient care through appropriate utilization of resources in a cost effective and timely manner.

Seaside ensures that members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment.

Seaside UM Program has established processes by which the Plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers/practitioner of health care services for plan members. These processes ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

Seaside will abide by the timeliness standards for medical determinations including pharmacy and notification of members/providers as referenced in:

1. ICE UM Timeliness Standards for CA Medicare Advantage (Attachment A);
2. Medi-Cal requirements;
3. DHCS regulations;
4. Welfare & Institution Codes: 24 hours / 1 business day on all drugs that require prior authorization.

The Plan policy on the Separation of Medical Services from Fiscal and Administrative Management is distributed via the website for providers and members. As well, a written notification is sent to providers and practitioners of the availability of the information on the Plan website and paper copies are made available upon request.

Seaside requires providers, practitioners and staff who participate in UM processes to sign the Separation of Medical Services from Fiscal and Administrative Management Acknowledgement at least every 2 years (Attachment B).

Seaside requires the Separation of Medical Services from Fiscal and Administrative Management and demands the following:

1. UM decisions are based only on appropriateness of care and service and existence of coverage;

2. No specific rewards to providers/practitioners or other individuals for issuing denials of coverage or service care;

3. No financial incentives for UM decision makers for decisions that result in underutilization;

4. Confirmation that consumer healthcare is not compromised by financial influences;

5. Ensured independence and impartiality in making referral decisions that will not influence:

    a. Hiring;

    b. Compensation;

    c. Termination;

    d. Promotion;

    e. Any other similar matters.

Seaside ensures that its participating providers/practitioners are utilizing UM criteria based on national, evidence-based standards that are appropriate for the Plan members. Seaside complies with national coverage decisions, general Medicare coverage decisions, general Medicare coverage guidelines, and written coverage decisions of local Medicare.

Seaside UM Program policies and procedures and description of the process by which the plan reviews and approves, modifies, delays or denies requests by providers/practitioners prior to, retrospectively, or concurrent with the provision of health care services to members, are filed with the Director of DMHC for review and approval, and shall be disclosed by the Plan to providers/practitioners and members upon request, and by the Plan to the public upon request.

Seaside ensures that no authorization shall be rescinded or modified after the provider renders the health care service in good faith for any reason, including, but not limited to, subsequent rescissions, cancellations or modification of the member's contract or when the delegate did not make an accurate determination of the member's eligibility.

Seaside has established policies and procedures for standing referrals of 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 member’s health care, including HIV/AIDS. Seaside disseminates these policies to primary care providers.

The Plan appropriately approves the treatment plan or a current standing referral to a specialist or specialty care center when a member requires specialized medically necessary care over a long period of time.

Seaside uses the Language Assistance Services of the Primary Plan when needed/required.
If the Primary Plan, Seaside provides access for members and practitioners seeking information about the UM process and the authorization of care through its toll-free 24-hour Member Service telephone line. As well, for its Limited English Proficient members, Seaside provides access to 24- hour health care interpreter services, including American Sign Language (ASL), and Telephone Services for the Hearing Impaired (TTD/TTY). Interpretation services can be arranged to ensure that communication in the member's preferred language is available.

Seaside provides access to UM Staff for members and practitioners seeking information about the UM process, issues and the authorization of care. UM Staff are available to receive inbound communication (via telephone, fax, Plan provider portal or electronic messaging) at least eight hours a day during normal business hours. Staff identify themselves by name, title and Seaside when initiating or returning calls regarding UM issues.

After business hours and weekend, calls the toll-free Member Services related to UM issues are triaged as follows:

1. Request for urgent UM issues are triaged to UM staff 24 hours a day 7 days a week.

2. Member or providers/practitioners requesting non-urgent or routine UM service requests may leave a message for follow- up during normal business hours.

Information on how to access UM staff for UM issues are included in provider manuals, member handbook, newsletters and/or when Seaside is Primary Plan on the member's identification cards.

Seaside ensures that the physician reviewer who denied, delayed or modified a request for health care services based on medical necessity is available via telephone to practitioners/providers who requested the authorization to discuss the UM determination.

For urgent care decisions, the Plan allows a health care practitioner with knowledge of the member's medical condition (e.g., a treating practitioner) to act as the member's authorized representative.

The UM Program and Plan are consistently and systematically monitored quarterly and evaluated yearly. The evaluation process is fully documented and opportunities for improvement are addressed. Oversight and reporting of utilization activities are the responsibility of the UM Committee and Chief Medical Officer as indicated in organization charts.

Organizational Structure and Responsibilities

Governing Body: responsibilities include the development, maintenance and oversight of the UM Program. The responsibility for creating and implementing the UM Program's infrastructure may be delegated to the UM Committee which will report to the Governing Body on at least a quarterly basis via report from the Quality Council.

Senior Vice President: responsibilities include oversight of the organization and management of the UM Program with a focus on the UM Program's financial viability, allocation of resources and staffing, and the interdepartmental effectiveness of the program.

Chief Medical Officer: is a designated physician with a current unrestricted license to practice in the state of California The Chief Medical Officer ensures that the process by which the plan reviews and approves, modifies, or denies, based 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. Responsibilities include:

1. Substantial involvement in UM Program operations through active participation in the development, implementation, supervision and continuous improvement of the UM Program, setting policies, reviewing cases and chairing the UM Committee meetings;

2. Signed Separation of Medical Services from Fiscal and Administrative Management Acknowledgement at least every 2 years.

3. Provides guidance and is responsible for all clinical direction and aspects of the UM Program;

4. If necessary, consultation with practitioners in the field is obtained;

5. Ensuring a behavioral health provider has involvement in key aspects of the UM Program, such as setting policies, reviewing cases and participating in the UM Committee meetings.

The Utilization Management Director: is responsible for the operational execution of the UM Program under the direction of the Director of Operations and the Chief Medical Officer.

1. Responsible for 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;

2. Responsible for the operations and management of staff assigned to all UM, Case Management and Care Coordination activities for Seaside, including monitoring and reporting as required by regulation or contract. The UM Director is responsible for managing the UM staff which may include, but not be limited to, the following positions: UR Coordinator, UM Nurse, Case Management Coordinator, Case Manager, HMO Coordinator, UM Clerk.

3. Supervise UM review decisions;

4. Signed Separation of Medical Services from Fiscal and Administrative Management Acknowledgement at least every 2 years.

5. The UM Director must have a current license..

Staff: personnel, analytic capabilities, data resources, and information systems needed to support and meet the UM program needs are defined in role descriptions and staff ratios that are tied to work needs and job descriptions.

1. Signed Separation of Medical Services from Fiscal and Administrative Management Acknowledgement at least every 2 years;

2. Verification of staff and consultant current licensure and credentials is performed upon hire or contract and thereafter upon license or certification expiration timelines or no more than every 2 years. Staff and consultants are required to notify the organization immediately if there are any adverse changes to licensure or certification status. If adverse changes are noted, then corrective actions are implemented to respond to those changes.

3. Registered Nurses and/or Licensed Vocational Nurses may approve UM referrals that meet the UM Committee's current approved evidenced based UM criteria; referrals that do not meet evidenced based UM approved criteria must be sent for physician review.

4. Non-licensed staff may approve UM referrals that meet the UM Committee's current approved list of auto authorizations as outlined in UM policies and procedures; referrals that do not meet the approved list of auto authorization must be sent for nurse or physician review

Utilization Management Committee: meets at least 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. Subcommittee activity and documentation must be presented to the UM Committee, if applicable.

1. UM Committee composition (at a minimum, 3 practitioners of primary care and specialty care must be represented, as regular committee attendees). 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.

2. Signed Separation of Medical Services from Fiscal and Administrative Management Acknowledgement at least every 2 years.

3. Practitioner participation in UM Committee meeting discussions represents a broad spectrum of specialties as appropriate and ensure practitioner participation in the UM Program through planning, design, implementation or review. Physician consultants from appropriate specialty areas of medicine and surgery and/or additional specialty sources/organizations specified are available to review cases pertaining to their specialty.

4. Primary Plan representatives may attend the UM Committee meeting if needed.

DEFINITIONS

Benefit Determination: is a denial of a requested service that is specifically excluded from a member's benefit plan, which the plan is not required to cover under any circumstances (e.g., in vitro fertilization). Benefit determinations include the following:

- Denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan.

- Decisions about care that do not depend on any circumstances, such as the member's medical need or a practitioner's order.

Concurrent review: is any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.

In Writing: letter communication via mail, fax, email, or online.

Organizational Determinations: any determination (whether adverse, fully favorable or partially favorable) for any of the following:

- Requests for service

- Discontinuation of service that the enrollee believes should be continued because they believe the service to be medically necessary.

- Refusal to pay for services in whole or part, including the type or level of services that enrollee believes should be furnished by the Medicare Advantage organization.
- Payment for any health services furnished by a provider other than the Medicare Advantage organization that the enrollee believes are covered under Medicare or if not covered by Medicare, should have been furnished or arranged for by the Medicare Advantage organization.

- Payment for temporarily out of area renal dialysis services, emergency services, post stabilization care, or urgently needed services.

- Failure of Medicare Advantage organization to approve, furnish, arrange, or provide the enrollee of timely notice of an adverse determination, such that a delay may adversely affect the health of the enrollee.

  Routine (non-expedited or Standard) Organization Determinations: made using appropriate clinical and CMS coverage guidelines and the member is notified within 14 calendar days of receipt of the request, per Medicare timeliness standards.

  Reconsideration: a request made to appeal the decision to deny the member's request for an item or service in whole or in part or issues an adverse organization determination.

Pre-service Request: is any case or service that the Plan must approve, in whole or in part, in advance of the member obtaining medical care or services. Pre-authorization and pre-certification are pre-service requests.

Post-service Request: is any review for care or services that have already been received (e.g., retrospective review). A request for coverage of care that was provided by an out-of-network practitioner and for which the required prior authorization was not obtained is a post-service decision. Although the Plan requires prior authorization of out-of-network care, post-service decisions include any requests for coverage of care or service that a member has already received. If the Plan, receives a request for coverage of an acute inpatient stay after the member's discharge, the Plan considers the request to be a post-service issue.

Prudent layperson: 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 medical treatment. A prudent layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, based on observation of the medical symptoms, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.

Terminal Illness: An incurable or irreversible condition that has a high probability of causing death within one year or less.

Time of receipt: when the request is made to Seaside in accordance with its reasonable filing procedures, regardless of whether the Plan has all the information necessary to make the decision at the time of the request. For Non-urgent requests (e.g., post-service requests) via a fax machine received after normal business hours, the time of receipt is considered as the next business day.

Triage and Referral: is a process for assessing a member's needs, determining the appropriate level of service and connecting the member with that service.

Urgent care: any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or

- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

I. Decision Making and Time Frames

Seaside ensures that UM Program processes for review and approval, modification, delay or denial of medical and behavioral health care services and medical necessity denials are consistently applied and will not interfere with or cause delay in service, or preclude delivery of services.

Seaside has lists of board-certified consultants that maybe used appropriate circumstances to assist in making medical necessity determinations (Attachment C).

The UM Director and CMO supervises review of UM decisions and a qualified Peer Reviewer will review denials if needed.

For mental health services, Seaside requires the involvement of a psychiatrist or other licensed mental health professional in decisions to deny or modify mental health services.

Seaside ensures that upon receipt of the information, decisions to approve, modify, or deny requests by providers/practitioners are conducted in a timely fashion and are not unduly delayed for medical conditions requiring time sensitive services and are consistent with Primary Plan required timeframes that is reasonably necessary to make the determination.

Seaside will abide by the timeliness standards for medical determinations and notification of members/providers as referenced in ICE UM Timeliness Standards for Commercial, and CA Medicare Advantage (http://iceforhealth.org/home.asp).

II. UM Criteria

A. Seaside established UM criteria to ensure that criteria used to make UM decisions are appropriate.

B. Written UM criteria used to authorize, modify, or deny healthcare services, and procedures for applying them, are developed, reviewed at least annually and updated as necessary utilizing and referencing established UM criteria standards. The annual review, discussion and approval of UM criteria will be reflected in the UM Committee minutes.

C. Appropriate actively practicing health care providers/practitioners will be involved in the development, adoption, and application of medical and behavioral health care (BH) UM criteria.

D. UM criteria include appropriate setting, LOS, practitioner type, and indications/contraindications for requested service. Criteria are objective, measurable, based on sound clinical evidence, and the individual needs of the members and characteristics of the local delivery system such as but not limited to whether services are available within the service area and benefit coverage.

E. The following factors are considered when applying UM criteria to the given individual: age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable.

F. UM criteria at a minimum are:

1. In accordance with generally accepted standards of medical practice; and

2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and

3. Not primarily for the convenience of the covered individual, physician or other health care provider; and

4. 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.

G. The written UM criteria application hierarchy is as follows:

1. Federal or State Mandate;

2. National Coverage Determinations

3. Local Coverage Determinations

4. Health Plan Medical Policy or Clinical Guideline;

5. Standardized Criteria (Milliman Care Guidelines);

6. Standardized Behavioral Health Criteria (Milliman Care Guidelines);

7. Provider Group Criteria or Guideline;

8. Community Resources (peer reviewed journals or published resources);

9. If none apply, professional judgment or case discussions is used.

H. For members with complicated length of hospital stay or for a delivery system with insufficient alternatives to inpatient care, the Plan considers at least the following when applying criteria to a given individual:

1. Age.

2. Comorbidities.

3. Complications.

4. Progress of treatment.

5. Psychosocial situation.

6. Home environment, when applicable

7. Availability of skilled nursing facilities, sub-acute care facilities or home care in the Plan's service area to support the member after hospital discharge.

8. Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed.

9. Local hospitals' ability to provide all recommended services within the estimated length of stay.

I. Seaside may address the aspects listed above as part of the UM criteria or in separate, overriding instructions to staff as indicated on the CM procedures, general UM procedures or online instructions in the following forms:

1. One or more sets of standing written instructions for staff to follow in every case to determine whether UM guidelines are appropriate for each member.

2. Specific instructions tailored for each procedure or diagnosis, or for groups of procedures or diagnoses, that led to a decision appropriate for the member.

J. Written UM procedures direct decision makers to alternatives when factors indicate that UM guidelines are not appropriate.

III. Dissemination of UM Criteria

A. Seaside provides written policies, procedures and clinical support tools to UM staff to use the UM criteria appropriate to their job.

B. Initial screening scripts and algorithms are developed to support UM staff (including non-clinical staff) and are approved by the UM Director and Chief Medical Officer.

C. Seaside UM policies and procedures and UM criteria are available to practitioners and providers including primary care, specialty, and mental health providers any time via Seaside's website provider portal.

D. Seaside UM policies and procedures and UM criteria are available to members, and/or member representatives any time via Seaside's website member portal or upon request.

E. Seaside dissemination of UM policies/procedures and UR 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 need and the benefits covered under your contract."

F. Seaside keeps a record of requests for disclosure requests and copies of responses to providers, members, and the public.

IV. UM Medical Necessity Decisions

A. Requests for authorization can be made over the phone or in writing by the member, member's representative, or physician.

B. When making a determination of coverage based on medical necessity, Seaside obtains and document in the file, relevant clinical information (only the information which is reasonably necessary to make a determination) and consult with the treating physician, as necessary.

1. Clinical information includes, but is not limited to, the following.

a. Office and hospital records.
b. A history of the presenting problem.

c. A clinical exam.
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. Photographs.
j. Operative and pathological reports.
k. Rehabilitation evaluations.
l. A printed copy of criteria related to the request.
m. Information regarding benefits for services or procedures.
n. Information regarding the local delivery system.
o. Patient characteristics and information.
p. Information from responsible family members.

C. Referral review and decision processes are based on eligibility, plan benefits, review of member medical record and review of UM criteria to determine medical necessity. All medical necessity decisions are supervised by an appropriately licensed professional.

D. Only the information necessary to approve the admission, procedure, or treatment, length of stay or frequency or duration of services is collected.

E. Information that will assist in the review process is accepted from any reasonably reliable source such as patient records and conversations with appropriate physicians.

F. Under the supervision of licensed personnel using standard work, defined UM criteria and decision trees, unlicensed UM staff may authorize requests with no modifications.

G. Request for authorizations with no defined standard work, UM criteria and decision tree or request for authorization that requires modifications can be approved by the UM Nurse with a current, unrestricted license or, if the license is restricted, there are guidelines in effect to ensure that job functions do not violate the restrictions imposed by the State Board.

H. Seaside ensures that only a qualified physician reviewer can deny/modify/defer authorization requests based on medical necessity.

I. Appropriate behavioral health care practitioner or pharmacist, as appropriate, participates in reviews of any behavioral healthcare denial of care based on medical necessity.

J. Another licensed physician or a licensed health care professional, competent to evaluate clinical issues related to requested health care services, shall re-review appealed denials or modifications.

K. Hospitals, physicians, and other providers are not routinely required to numerically code diagnoses or procedures to be considered for approval but Seaside may request such codes, if available.

L. Approval determinations are not reversed unless new information received is relevant to the approval that was not available at time of original approval and the service has not yet been rendered.

M. Seaside does not routinely request copies of all medical records on all patients reviewed, and only the section(s) of the medical records necessary in that specific case to determine medical

necessity or appropriateness of admissions or extension of stay, frequency or duration of service, or length of anticipated inability to return to work is required.

N. Seaside has established process for sharing all clinical and demographic information on individual patients among various clinical and administrative departments that have a need to know to avoid duplicate requests for information from members or providers.

O. For pre-service and concurrent review, review of determinations is based solely on the medical information obtained by Seaside at the time of the review determination.

P. For post-service review, review of determinations is based solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

Q. Denials are not issued based on initial screening.

R. Denials are not issued based on initial clinical review.

S. Non-MediCal benefit determination are not require to be reviewed by an appropriate practitioner of requests for medical services that are specifically excluded from the benefit plan although Seaside may authorize exceptions to the benefit plan. If the Plan authorizes a service, grants an extension of benefits or makes an exception to a benefit limitation in the member's benefit plan (e.g., the plan is required to approves 100 visits but allows 101 visits), a subsequent denial of the same service or a request for an extension or exception is not considered a medical necessity determination.

    1. Decisions on personal care services, such as transportation, cleaning and assistance with other ADL-related activities, are considered benefit determinations. However, these benefit decisions are appealable.

V. Emergency Services

A. Seaside ensures that prior authorization is not required for the provision of emergency services and care to a patient with a psychiatric emergency in the following situations:

    1. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed;

    2. If an authorized representative, acting for the Plan, authorized the provision of emergency services.

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

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

C. Seaside may deny ER claims based on lack of information from the member or practitioner, but allow members and practitioners at least 45 calendar days to provide the requested information before denying the claim based on lack of information. Members have the right to appeal denied ER claims.

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

D. ER denials are treated as benefit issues cases that can be identified as workers' compensation claims.

VI. Practitioner Review of Denials for Medical Necessity

A. Medical Health Care Denials

1. Seaside ensures that only a licensed physicians or a licensed health care professional, competent to evaluate clinical issues related to requested health care services make decisions, to deny or modify requested services on the basis of medical necessity of health care services offered under the Plan's medical benefit.

2. Situations that represent medical necessity determinations because the provision of coverage for them depends on the circumstances can be:

a. Covered medical benefits defined by the Plan, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits.

b. Pre-existing conditions when the member has creditable coverage and the Plan has a policy to deny pre-existing care or services.

c. Procedure or treatment that might be considered experimental in some instances or not experimental in others;

d. Procedure that might be considered either cosmetic or medical, depending on the reason (e.g., breast reduction surgery for back pain);

e. Referral to an out-of-network practitioner that might not be considered a covered benefit if the service in question can be provided within the network, or might be considered a covered benefit if no in-network practitioner has the appropriate clinical expertise;

f. Pharmaceutical that might be considered a covered benefit if the member has used the recommended prerequisite drug of a step-therapy protocol.

g. Medical procedures performed by oral surgeons:

i. Reduction, dislocation or excision of the temporomandibular joint.

ii. Correction of accidental injuries to the jaw, cheeks or palate.

iii. Excision of tumors and cysts of the jaw, cheeks or palate.

iv. Treatment required as part of a medical condition or injury that prevents normal function of a bone or joint.

3. Because each case is unique and the classification of a procedure or treatment as "experimental" or "investigational" can be a matter of interpretation with differing opinions between the Plan and the treating practitioner, medical necessity review of

such requests is required unless the requested service or procedure is specifically listed as an exclusion in the member's benefit plan.

B. Behavioral Health Care Denials

1. Seaside ensures that a physician, appropriate behavioral health care practitioner or pharmacist, as appropriate, reviews any behavioral healthcare denial of care based on medical necessity.

2. Medical necessity determinations for behavioral health care can include:

   a. A chemical dependency admission, when the member's benefit plan covers a chemical dependency treatment.

   b. A procedure or treatment that might be considered experimental in some instances or not experimental in others.

   c. A referral to an out-of-network practitioner that might not be considered a covered benefit if the service in question can be provided within the network, or might be considered a covered benefit if no in-network practitioner has the appropriate clinical expertise.

   d. A denial of a member's request for continued inpatient behavioral healthcare treatment because it has determined that the member's treatment can be managed appropriately in an outpatient setting.

   e. A denial of a member's request for electroconvulsive therapy (ECT) because the organization has determined, through a review of its clinical criteria, that other methods of treatment should be attempted first, unless contraindicated.

C. Documentation of appropriate professional review

1. Documentation are consist of:

   a. A handwritten signature, handwritten initials or unique electronic identifier on the letter of denial or on the notation of denial in the file.

   b. 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.

2. Medical denial files contain documentation that a physician reviewed all denial decisions for medical services based on medical necessity

3. Pharmaceutical denial files contain documentation that a physician or a pharmacist reviewed all denial decisions for pharmaceutical services based on medical necessity.

4. Dental denial files contain documentation that a physician or dentist reviewed all denial decisions for dental procedures made based on medical necessity.

5. Chiropractic denial files contain documentation that a physician or chiropractor reviewed all denial decisions for chiropractic services based on medical necessity.

6. 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.

VII. Communication of UM Decision

A. Provider/practitioner notified of decisions to approve, deny, delay, or modify health care services orally or in writing within 24 hours of making the decision. Member is notified of decisions to approve, deny, delay, or modify health care services in writing within 2 business days of making the decision.

B. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third Working day after the decision is made, not to exceed 14 calendar days from receipt of the original request for Medi-Cal and 30 days for Healthy Families/Healthy Kids

C. Approval of requested services:

1. In writing information includes the specific health care service approved, the approved provider/practitioner, the approved facility and approved dates of service, as appropriate and tracking information (such as reference number) for the approval;

2. Confirmation of approval for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services;

    a. Seaside ensures that the frequency of reviews for the extension of initial determinations is based on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity (e.g., not routinely conducted on a daily basis).

D. Denial, delay or modification of requested services

1. Members and practitioners receives sufficient information in the Notice of Action letter to understand and decide whether to appeal a decision to deny, modify, or delay care or coverage.

2. Seaside clearly documents and communicates the reasons for each denial including:

    a. A clear and concise in writing explanation of the reasons for the Plan's decision to deny, delay, or modify health care services;

    b. A description of the criteria or guidelines used for the Plan's decision to deny, delay or modify health care services;

    c. The clinical reasons for the Plan's decision to deny, delay, or modify health care services;

3. The name and the direct telephone number of the provider/practitioner responsible for the denial, delay, or modification;

4. Member's Rights to:

a. Appeal within at least 90 days (Medi-Cal) 180 days (HF/HK) to appeal the decision through the Health Plan's grievance/appeal process;

b. Appeal to the Department of Managed Health Care (DMHC) 'Ombudsman Office' for answering questions or help in appealing the decision if not satisfied with the decision at the Plan Level;

c. A written copy of the criteria or benefit provision used in the decision upon request;

d. Be represented by anyone the member chooses including legal counsel, friend, or other spokesperson and have that representative act on their behalf at all levels of appeal;

e. Submit written comments, documents or other information relevant to the appeal;

f. Have benefits continue pending the resolution of the appeal and how to request continued benefits;

g. and method of obtaining, a fair hearing to contest the denial, deferral, or modification action and the decision the Delegate has made;

5. Information on how to file a grievance;

6. Information on how to request an independent medical review in cases where the member believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers/practitioners.

7. De-identification of the member’s social security number.

8. Names of copied practitioners

9. Notice of availability of translation and interpreter services.

10. The State’s toll-free telephone number for obtaining information on legal service organizations for representation.

11. Benefit denial notifications include a reference to the specific benefit provision that excludes the health care service requested.

12. Denial notifications 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.

13. Denial notifications instruct the member to contact the requesting practitioner/provider for explanation of diagnosis and treatment codes.

VIII. Disclosure of UM Process to Authorize or Deny Services

A. Seaside discloses or provides for the disclosure to the Director of DMHC and to network providers the process the Plan, its contracting provider groups, or any entity with which the Plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the Plan,

including coverage for sub-acute care, transitional inpatient care, or care provided in skilled nursing facilities.

B. Seaside discloses above processes to members or persons designated by the member, or to any other person or organization, upon request.

C. The disclosure to the Director of DMHC includes the policies, procedures, and the description of the processes that are filed with the director of DMHC.

D. Seaside discloses to the member and provider the UM criteria used as a basis to modify, deny or delay services in specified cases under review.

1. UM criteria are available to the public upon request, which may include the availability through electronic communication means.

2. Disclosure of UM criteria to the public are accompanied by the following notice:

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

IX. Appeals

A. Seaside, as a delegated plan serving members under a plan to plan agreement with a MediCal Managed Care Plan or other Primary Health Plan is not delegated appeals or Independent Medical Review functions. Seaside takes actions as required by the Primary Health Plan and in alignment with the requirements of the Department of Managed Health Care including providing any relevant medical information such as the member's medical condition, health care services being provided and any disputed health care services to the health plan. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

X. UM Processes as Part of the QI Program

A. Seaside implements a tracking system for all UM Referrals for documentation/identification of request status:

1. UM Referral requests, decisions, notifications and all pertinent related actions are documented in the applicable UM file;

2. Denials and appeal outcomes are tracked and trended in order to identify potential issues with over or under- utilization patterns. The UM denial and appeal data is reviewed by the Plan UM Committee;

a. The Chief Medical Officer or a qualified Physician Reviewer reviews all denials/modifications that are made, in whole or in part, on the basis of medical necessity, and care or services that could be considered either covered or non-covered, depending on the circumstances.

3. For all telephonic notifications, practitioner/provider/member name, the time, date, and signature of the person who spoke with the practitioner/provider/member are documented.

B. Over/Under Utilization Monitoring/ Detection/ Correction

1. Seaside descriptions of over/under utilization monitoring/detection systems includes monitoring inappropriate emergency room usage for routine primary and specialty care and the review of services for appropriateness and effectiveness of cost effective patient care for detecting/correcting over- and under-utilization.

    a. Seaside's UM Committee performs the following over/under utilization monitoring/detection mechanisms:

        i. Use of Services

            - Frequency of Selected Procedures
            - Inpatient Utilization - General Hospital/Acute Care
            - Ambulatory Care
            - Inpatient Utilization - Non-Acute Care
            - Mental Health Utilization - Inpatient Discharges and Average Length of Stay Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
            - Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay
            - Identification of Alcohol and
            - Other Drug Services Outpatient Drug Utilization (for those with a drug benefit)

        ii. Ambulatory and Hospitalization Services: encounter data and Seaside claims data that includes:

            - Outpatient Services: Primary Care, Specialty Care, Ancillary Services Emergency Room utilization Hospital Services, Bed Days, Average Length of Stay and Hospital Readmissions
            - Emergency Room Reports: monthly and rolling report for analysis by the UM Committee. Trends in Emergency Room Department utilization may indicate access, education or under-utilization issues at any of these levels while indicating over-utilization at the Emergency Room level.
            - Hospitalization Admit and Re-admit data are studied by utilizing encounter data and analyzing reports at Seaside level that indicate a trend of admission and re-admission for same/similar diagnosis. If a pattern is found at any level, the possibility of under-utilization of inpatient services or outpatient support services may exist and warrant further investigation.

    b. Seaside's internal reporting mechanisms used to detect member utilization patterns shall be reported to the Primary Plan and/or DHCS upon request.

i. Quarterly Reports are consistently submitted to on a timely basis and include identification and reporting mechanisms of Over/Under Utilization, including action plans implemented as necessary to improve detected over/under utilization patterns.

C. Evaluation, monitoring and assessment of compliance:

1. Seaside evaluates complaints and assesses trends to identify potential quality issues in the UM process and quarterly report this information to the Quality Council;

2. On-going monitoring and assessment of compliance to UM requirements:

a. Timeliness of decision-making;

b. Timeliness of notification;

c. Turnaround times for UM functions;

d. Use of appropriate licensed health care providers in making denial decisions;

e. Denial letters include the required information;

f. Appropriate use and application of criteria in making medical necessity decisions;

g. In writing communication to the appropriate providers/practitioners and/or members;

h. After hours referral management processes including after hour calls for authorization;

i. Has a process to identify Medicare Advantage Part C members and generates reports that comply with Medicare Advantage Part C Requirements. The VP of Operation in coordination with the Director of Utilization Management will oversee the production of appropriate reports through querying the claims and utilization management computerized systems at the required frequency of the CMS regulations submitted to Primary Plan as requested including but not limited to data for fully favorable, partially favorable and adverse determinations.

i. Seaside will report per the ICE Medicare Part C Report Template PPG Reporting of Medicare Organization Determinations or other Primary Plan approved templates.

D. Member Access

1. Seaside's quality assurance/utilization review mechanism encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the Plan and/or delegated providers.

2. Seaside have a process in place that assess, routinely monitors, and analyze evaluation of access to specialist care, ancillary support services, and appropriate preventive health services.

a. Seaside routinely monitors authorization against claim data to determine if authorizations have not been accessed by members. Seaside coordinates follow-up with PCP to determine next steps for unused authorizations.

b. Seaside maintains a specialty referral tracking system for managing specialty referral requests that tracks the specialty referral to completion and includes mechanisms to monitor members/practitioners who do not follow-up on the specialty referral and also ensures the referring practitioner receives a consultative report from the specialist

3. Seaside identify, communicate, and implement corrective actions when potential access issues are identified in the UM process

4. Seaside evaluates the effectiveness of any corrective actions using performance measures and makes further recommendations to improve potential access issues.

E. Inter- Rater Reliability

1. Annually, Seaside evaluates the consistency with which health care professionals involved in Utilization Management apply criteria in decision making and act on opportunities to improve consistency

a. Inter-rater Reliability assesses the consistency with which both physician and non-physician reviewers apply UM criteria as follows:

i. Physician reviewer and nurse application of criteria for determining medical appropriateness,
ii. Nurse and technician application of approved auto authorizations according to UM Committee approved list of auto authorization, and

iii. Physician reviewer and nurse application of criteria specifically for the review of medical necessity for benefit coverage as required in the member's handbook and/or interpretation of benefits.

b. Methods utilized to ensure inter-rater reliability may include random review of selected authorizations by peers, side by side comparisons of different UM staff members managing the same cases, weekly UM rounds attended by UM staff members and physicians to evaluate determinations and problem cases, or periodic audits of determinations against criteria.

i. If the Plan chooses to use a sample of UM determination files, it may use any one of the following auditing methods: 5 percent or 50 of its UM determination files, whichever is less, or NCQA "8/30 methodology." available at http://www.ncqa.org/updates, or another statistically valid method

c. Assessments and assessment results are documented and reported by the Plan UM Director to the Quality Management Committee (QMC), UM Committee and the UM reviewers.

d. Problem identification, corrective action, intervention/education, re-measurement must be conducted as applicable.

e. Identified quality issues should be reported to the QMC as applicable.

F. Identification of potential quality issues of the UM process:

1. The UM Committee is responsible in identifying potential quality issues in the UM process and recommending, developing, approving and monitoring performance improvement and Corrective Action Plans (CAP) to improve the UM process;

2. The UM Committee will be responsible for identifying any variance from the standard of care, either as a sentinel event or if an unjustifiable adverse outcome warrants immediate action based upon a pattern of practice which falls out of the established program and community standards over a period of time;

3. When UM concerns are identified, a CAP is required to be approved by the UM Committee. A CAP may include but is not limited to: provider education, member education, staff development, administrative changes, provider contract changes and alteration of credentialing;

4. UM Committee evaluates the effectiveness of any CAP using performance measures and make further recommendations to improve the UM process.

G. Member and provider/practitioner satisfaction

1. Seaside evaluates member and practitioner satisfaction with the UM process at least annually, through methods that may include but not be limited to:

a. Member and practitioner satisfaction surveys

b. Member and practitioner complaints and grievances that specifically relate to UM. The Plan develops a mechanism for categorizing complaints and appeals in various UM processes and tracking them by category, and sets performance thresholds.

2. The UM Committee performs the following review of the results:

a. Addresses areas of dissatisfaction by implementing improvement actions that are likely to have a positive impact on member and practitioner satisfaction.

b. Evaluates results of interventions

H. Annual UM Program Evaluation

The UM Committee reviews and revises the UM Program annually and as needed. Any structure and organizational changes to the program are reviewed and approved by the UM Committee, Quality Council and the Board of Directors.

XI. Organizational Determinations (See Attachment A)

A. Members' requests for standard organization determinations can be submitted orally or in writing.

1. All request are submitted to the UM Department and oral request will be documented in writing by the UM Staff.

2. Information on how to submit UM requests are communicated in Seaside's website and member communication materials.

XII. Expedited Determination for urgent requests

A. To request an expedited determination, member or a physician must submit orally by calling the Member Services or in writing through fax or mail request directly to Primary Plan or to Seaside when delegated. Urgent requests for services are referred depending upon the entity responsible for reviewing the referral request.

    1. All oral requests will be documented in writing and maintained in a case file.

B. Urgent referral requests are submitted when services are required to prevent serious deterioration of health following the onset of an unforeseen condition or injury. Urgent referral requests made will be reviewed to assess whether the care requested meets the definition for urgent processing. If request is approved for urgent processing, Primary Plan or Seaside, when delegated, makes its determination and notifies the members and the physician involved of its decision (whether adverse or fully favorable , partially favorable or adverse) as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request or an additional 14 calendar days if an extension is justified.

    1. When members are notified of the decision for expedited determination orally, a written confirmation will be mailed to the member within 3 calendar days of the oral notification.

C. Based on CMS standards, referrals that do not meet the criteria for urgent processing will be reviewed by the Medical Director. If the service requested does not meet the criteria for an urgent request, the referral request will be converted to a routine request for processing within the standard timeframe which is 14 calendar days from the date and time of the request. Members may file an expedited grievance if they do not agree with the decision.

D. If the referral request does not meet criteria for medical necessity or covered benefit, these requests are subject to a modification or denial by the Medical Director. Provider will be notified by UM staff member prior to the change in referral status. Appropriate communications are sent to the member and provider. If the services are denied, the denial notice must be the appropriate CMS approved denial letter (Notice for Denial of Medical Coverage, NDMC) and including the reason for the denial, the criteria used, and include Medicare appeal rights.

E. A physician will make all determinations of deferment, modification or denial of requests for services.

XIII. Adverse Standard Pre-Service Organization Determinations

A. Seaside notifies members of adverse standard pre-service organization determinations in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC

    1. Timeliness: of its decision as expeditiously as the member's health condition required, but no later than 14 calendar days after receiving the request (or an additional 14 days, if an extension is justified

    2. Notice Content: clearly stating the service denied and the specific denial reason.

3. Appeal Rights: and inform the member of his or her right to a standard or expedited reconsideration, including the rights to, and conditions for, obtaining an expedited reconsideration, as well as describe the appeal process.

XIV. Detailed Explanation of Non-Coverage

A. Seaside, upon notification by the QIO that a member has filed a request for a fast- track appeal, must send the written CMS-10095-B (Detailed Explanation of Non- Coverage) to the member by the close of business on the day the QIO notification is received

B. Seaside will include in the (Detailed Explanation of Non-Coverage)of Provider Services (CMS-10095-B) an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction, or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.

XV. Investigational and Experimental Services

A. Seaside as a delegated Plan serving members under a Plan to Plan agreement will immediately refer requests for experimental or investigational treatments, including clinical trials, to the Primary Health Plan for initial determination, regardless of benefit exclusion. No denial of services considered experimental or investigational will be issued by Seaside under a Plan to Plan agreement.

1. 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.

2. 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; and

    b. The efficacy and safety of such services in human subjects are not yet established; and

    c. The service is not in wide usage

3. 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.

B. Seaside will refer the authorization request and all supporting medical records received to the Primary Plan per their described process.

C. When Seaside is the Primary Plan or when delegated, will immediately review requests recommended by a participating plan provider for experimental or investigational treatments, including clinical trials, for initial determination, regardless of benefit exclusion.

1. Experimental services are not covered

2. Investigational services are not covered 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 with it 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 patient'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 intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living.

3. 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.

XVI. Terminal Illness Requirements and Compliance

A. When Seaside is the Primary Plan, denies coverage of a request as recommended by a participating plan provider to member with a terminal illness for treatment, services, or supplies deemed experimental, all of the following information will be provided by Seaside to its member within 5 business days of receiving the request:

1. A statement setting forth the specific medical and scientific reasons for denying coverage.

2. A description of alternative treatment, services, or supplies covered by the Plan, if any.

3. Copies of the Plan's grievance procedures and Terminal Illness Complaint Form. The Plan’s Terminal Illness Complaint Form provides an opportunity for the member to request a conference as part of the Plan's grievance system.

a. Upon receiving a Terminal Illness Complaint Form requesting a conference, the Plan provides the member, within 30 calendar days, an opportunity to attend a conference, to review the information provided to the member conducted. The Plan representative attending the conference will have authority to determine the disposition of the complaint.

b. The Plan allows attendance, in person, at the conference, by an 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 the Plan 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.

XVII. UM Delegation and Oversight

A. Refer to Delegation of Plan Responsibilities Policy and Procedure (DR-200) for Pre-delegation, Transition of Delegation, Monitoring and Evaluation of Delegates, Improvement Actions, Delegation Revocation and Reconsideration of Delegation (Post Revocation).

B. Seaside allows delegate representatives to review the medical records and personal health information (PHI) of its members, consistent with applicable state laws. Mutually agreed upon delegation agreement will include this provisions through:

1. The Plan's policy on delegate's access to medical records including a list of the allowed uses of PHI;

2. A description of delegate safeguards to protect the information from inappropriate use or further disclosure'

3. A stipulation that the delegate will ensure that sub-delegates have similar safeguards as the Plan;

4. A stipulation that the delegate will provide individuals with access to their PHI;

5. A stipulation that the delegate will inform the Plan if inappropriate uses of the information occur;

6. .A stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends.

C. Delegated UM responsibilities may include:

1. Adopting criteria;

2. Monitoring the quality and timeliness of decisions;

3. Precertification, by service;

4. Urgent concurrent review;

5. Post-service review, by service;

6. Approvals and denials;

7. Appeals;

8. Establishing, applying and maintaining pharmaceutical management procedures;

9. Evaluating new technology;

10. Communicating with members about the UM process and authorization of care.

D. If Seaside delegates UM of Behavioral Health, the delegated description includes requirements for the behavioral health delegate to collaborate with the Plan on:

1. Improving the exchange of information between medical and mental health providers;

2. Improving the diagnosis, treatment and referral of mental health conditions in medical settings;

3. Improving access to treatment and follow-up for members with co-existing medical and mental health disorders.

E. Seaside ensures that each delegate:

1. Is provided with documents necessary for Seaside to conduct oversight such as:

a. Quality Management program descriptions;

b. UM policies and procedures;

c. Complaint handling.

2. Has a designated Chief Medical Officer who holds an unrestricted license to practice medicine in California;

a. The Chief Medical Officer's position description include substantial responsibility for providing clinical direction and oversight of the UM Program.

3. Has written criteria or clinical guidelines for UM decisions that meet the requirements and are clearly documented for each UM function along with the procedures for use/application of the criteria in making medical necessity determinations;

4. Submission of a Utilization Management Program Description and Case Management Program Description (if applicable);

5. Quarterly submission of Utilization Management statistics and Case Management statistics (if applicable);

6. Utilization Statistics will include:

a. Number of UM cases handled by type (pre-service, urgent concurrent, or post-service) and by service (inpatient or outpatient);

b. Number of denials made;

c. Number of cases appealed.

7. Annual audit of UM and CM files such as reports on UM medical necessity denials, medical necessity and benefit appeals, hospital admissions, length of stay, referrals,

denials and inpatient days per 1,000 members.

a. If the delegate is URAC and/or NCQA is accredited, submission of the delegate's URAC and/or URAC Case Management accreditation award replaces the need for audit of UM and CM files.

8. Evidence of performance of an annual evaluation and update of the delegate's UM Program and evidence of review by the appropriate committee/s such as through committee meeting minutes and records of communication with the delegate;

9. Delegate's UM Program has a clearly stated policy that denials of coverage for reasons of medical necessity are made by a qualified licensed physician or health care professional;

10. Delegate provides telephone access for providers to request authorization for health care services;

11. Delegate's timeframes for UM decisions are within the Plan's standard and regulations;

12. Delegate provides timely responses to provider requests for authorization;

13. Delegate's written notification for denials includes:

a. Name and direct contact number for the professional responsible for a denial, delay, or modification of an authorization;

b. Clear explanation of the reasons for the delegate's decision, a description of the criteria used, and clinical reasons for the decision regarding medical necessity;

c. Includes grievance and IMR information.

14. Delegate assesses the quality of their UM Program and processes and takes appropriate action when problems are identified;

15. Delegate has emergency health care services available and accessible within the service area 24 hours a day, seven (7) days a week;

16. Delegate reimburses for emergency services provided to its members until the care results in stabilization of the member and the delegate shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the member's emergency medical condition;

17. Delegate denies reimbursement to a provider for a medical screening examination only in cases where the member did not require emergency services and care and the member reasonably should have known that an emergency did not exist.

F. Seaside oversees the delegate to ensure that the delegate is properly performing the functions. Seaside may reclaim the right to carry out its delegated functions at any time.

G. Seaside is ultimately accountable for all functions performed within its purview. Seaside has policies and procedures for monitoring its delegated entities including methodology and conducts regular oversight of the UM Program for each of its delegated entities for compliance with its established UM standard.

H. Refer to “Delegation of Plan Responsibilities” Policy and Procedure (DR-200) for details of oversight activities.

XVIII. Mental Health Parity Coverage & Claims Administration

A. Seaside provides 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:

1. Maximum lifetime benefits;

2. Copayments;

3. Individual and family deductibles.

B. When Seaside is delegated to do so or is the Primary Full-service Health Care Plan, Seaside coordinates with the mental health plan to ensure that mental health parity benefits are being provided to its members.

1. Agreement between the Seaside and the carve-out mental health plan delegate mental health parity responsibilities to the mental health plan. The agreement includes how the mental health plan and Seaside coordinate the development of benefit design and descriptions of the collaboration between the mental health care plan and the Seaside for :

a. Timely exchange of information between medical and mental health providers;

b. Improving the diagnosis, treatment and referral of mental health conditions in medical settings;

c. Improving access to treatment and follow-up for members with co-existing medical and mental health disorders.

C. Seaside reviews and updates protocols on parity conditions, when appropriate, on a regular basis.

XIX. Mental Health Triage and Referral—Seaside, when delegated to do so in a Plan to Plan agreement or as a Primary Health Plan, either maintains or delegates:

A. A 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;

B. Policies and procedures and/or training that define protocols adopted for initial referrals to mental health providers. Protocols address the urgency of the patient's clinical circumstances and must define the appropriate care settings and treatment resources that are to be used for both mental health and substance abuse cases;

C. 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;

D. Established standards and goals for the timeliness of response to its triage and referral telephone lines and measures performance against those standards;

    1. If the Plan does not meet its goals, Seaside takes an appropriate corrective action;

    2. Seaside re-measures results after corrective action has been implemented.

E. Seaside ensures that only qualified licensed clinical staff members make decisions about the type and level of care to which members are referred;

F. Seaside ensures that prior authorization is not required for the provision of emergency services and care to a patient with a psychiatric emergency.

XX. Standing Referrals

A. Members, who require specialized care over a prolonged period for a life-threatening, degenerative or disabling condition, including Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), may be allowed a standing referral to a specialist who has expertise in treating the condition or disease for the purpose of having the specialist coordinate the member's healthcare.

    1. Specialists and specialty care centers are validated assure accreditation or designation as having special expertise in treating the condition or disease (Refer to "Credentialing" Policies and Procedures); List of specialists, including HIV/AIDS specialists (as defined by 28 § 1300.74.16), are updated at least yearly, kept in shared files easily available to UM and Case Management.

    2. Listings of specialists and specialty care centers, including HIV/AIDS specialists are available to PCPs via the website to assist in the referral process;

    3. The PCP can request authorization for an out-of-network specialist if one is not available within Seaside or the Primary Plan Networks who can provide appropriate specialty care to the member as determined by the PCP in consultation with Seaside's CMO as documented in the treatment plan.

B. The PCP, specialist and designated physician determines that continuing care from a specialist is needed and request authorization based on an agreed upon treatment plan, if any. Treatment plans may limit the number of specialist visits or the length of time the visits are authorized, and may require the specialist to make regular reports to the PCP.

C. The determination shall be made within three (3) business days of the date the request for the determination is made by the member or the member's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided.

D. If authorized, the actual referral will be made within 24 hours of the decision, specifying the specific services approved. Services shall be authorized as medically necessary for proposed treatment, of a duration not to exceed one year at a time, utilizing established criteria and consistent with benefit coverage.

E. The PCP retains the responsibility for basic case management/coordination of care unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the PCP contract with Seaside.

F. After receiving the standing referral approval, the specialist is authorized to provide healthcare services that are within the specialist's area of expertise and training to the member in the same manner as the PCP.

G. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, Seaside will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria.

H. Denial Letters for Standing Referrals will include:

1. Clear and concise explanation of the reasons for the denial;

2. Clinical reasons for the Plan's decision to deny, delay, or modify health care services.

I. Written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the following information:

1. The name of the health care professional responsible for the denial, delay, or modification;

2. The direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them.

J. Written communications to an member of a denial, delay or modification of a request include information as to how the member may:

1. File a grievance to the Plan;

2. Request an Independent Medical Review in cases where the member believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers.

XXI. Post-Stabilization Request for Authorization of Continuing Care

A. Seaside fully documents all requests for authorizations and responses to such requests for post stabilization medically necessary care. Documentation includes:

1. Date and time of the provider's request;

2. Name of the health care provider making the request;

3. Name of the Plan representative responding to the request.

B. Seaside requires prior authorization for post-stabilization care.

1. Seaside provides 24-hour access for patients and providers, including non-contracting hospitals, to obtain timely authorization for medically necessary post-stabilization care through the 24 hour, toll-free Member Services line;

2. The Plan responds to a hospital requesting post-stabilization authorization after the first call such that the requesting hospital does not have to make more than one call before it gets an initial response from the Plan;

3. If post-stabilization requests are denied, the decision is communicated within 30 minutes of the request;

4. If Seaside does not respond to a post stabilization request within 30 minutes, it will pay any claims submitted by the provider for the post stabilization care rendered.

C. Seaside widely distributes the 24 hour, toll-free Member Services line to all contracting and non-contracting hospitals to obtain authorization from the Plan for post-stabilization care.

XXII. Transfer to a Contracted Hospital

A. Seaside properly arranges for the transfer of members after the member has been stabilized subsequent to an emergency psychiatric or medical condition but the provider believes further medically necessary health care treatment is required and the member cannot be safely discharged.

B. Seaside ensures that a patient is not transferred to a contracting facility unless the provider determines no material deterioration of the patient is likely to occur upon transfer.

C. Seaside ensures that prior authorization is not required for the provision of emergency services and care to a patient with a psychiatric emergency.

XXIII. In-patient Admissions and Discharge Planning

A. Seaside will monitor the coordination of care provided to the Member, including but not limited to coordination of discharge planning from inpatient facilities, and coordination of all Medically Necessary services both within and outside of the provider network.

B. Seaside ensures discharge planning is initiated within 24 hours of notification of the admission and pre-admission status are documented where applicable.

C. Post discharge follow-up appointment with PCP :

1. To ensure continuity of care for the Ambulatory Care setting to the inpatient care setting, Seaside monitors and documents member's who made follow-up appointment with PCP post-discharge

2. If appointment was not made, Seaside makes and documents at least 3 attempts to contact member about the appointment (1st call to occur within 48 hours post discharge & 3rd call to occur within 7 business days) before sending a "missed appointment" or "unable to contact" letter.

D. When Seaside is alerted to information regarding a possible Quality of Care concern or the member complains about Quality of Care in the in-patient facility, Seaside will:

1. If not delegated, Seaside will forward member complaints to the Primary Plan;

2. If delegated, Seaside will request investigation and Corrective Actions per Quality Management Policy.

E. Early Discharge After Delivery

1. If the member, the physician or the hospital requests an early discharge after delivery, Seaside will authorize and reimburse for a home health visit.

F. Case Manager or designee follows member through continuum of care until the member is returned to his/her prior living arrangements, if possible.

XXIV. Confidentiality

A. Seaside has policies and procedures about confidentiality that apply to practitioners as well as to Quality Management (QM), UM and administrative staff and to all other staff members who have access to any member information. The Plan's Confidentiality Policies address the following:

1. Maintaining confidentiality of information within Seaside.

2. Protecting medical record information (both original information and documentation used for UM, QM activities and case management).

3. Protecting claims information.

4. Orienting employees to the Plan's confidentiality policies and procedures

B. All Seaside UM processes are to be conducted under confidential processes.

C. All member/patient information available at any of the delegated entities provider locations is confidential and protected from unauthorized dissemination by Seaside and its delegated entities.

D. All members and guests attending the UM Committee meetings are required to sign statements acknowledging confidentiality.

E. All contracts made by Seaside to providers/practitioners and delegates require them to have an appropriate policies and procedures to maintain the confidentiality of member records and information. Such statements are also signed annually

F. A process must be in place to assess the adequacy of office policies and procedures during site visits.

G. Seaside ensures members' right to authorize or deny the release of personal health information (PHI) beyond uses for treatment, payment or health care operations to obtain a member's permission before releasing confidential information outside the Plan

1. The Plan's confidentiality policies and procedures defines the uses for which the Plan obtains authorization from members for the release of PHI, and those for which it does not obtain authorization, and defines the contents of an authorization initiated by the Plan.

History: New

Origination Date: May 17, 2013