Seaside Health Plan Policies and Procedures	**Effective Date:** May 17, 2013 **Note: For origination date see History at end of policy.**
SUBJECT: REFERRAL AUTHORIZATION PROCESS	**Approval Signature:** Barry Smith, MD Chief Medical Officer
Manual: Utilization Management **Policy/Procedure #** UM-110 **Section:** UM Program	**Sponsor Signature:** Kimberly Ward, RN Director, Utilization Management
☒ **COMMERCIAL** ☒ **HEALTHY FAMILIES** ☒ **MEDI-CAL** ☒**MEDICARE**	

AUTHORITY

CA Health & Safety Code § 1367 and 1371
29 CFR § 2560.503-1

POLICY

Seaside UM Program details decision making, turn-around time frames, UM criteria, communication of UM decisions, terminal illness requirements to ensure processing of request for referral authorizations will not interfere with or cause delay in service, or preclude delivery of services. 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.

Referral Processes are consistent with Seaside UM Program. Decision making, turn-around time frames, UM criteria, communication of UM decisions and terminal illness requirements are followed per the UM Program to ensure processing of request for referral authorization will not interfere with or cause delay in service or preclude delivery of service.

DEFINITIONS

Automatic Authorization: Benefited services that do not require authorization for payment. These include the following:

Emergency Services	Basic Prenatal Care
Family Planning Services	Sexually Transmitted Disease Services
Preventive Services	HIV Testing/Counseling
Involuntary Psychiatric Inpatient Admission	

Direct Referral Authorization: In-network Primary Care Provider refers member directly for benefited service using the Direct Referral Authorization Form. Direct Referral Authorization is for 1 visit. These include the following:

Allergy & Immunology	Pulmonary Disease
Cardiology	Podiatry
Endocrinology	Rheumatology
Gastroenterology	Surgery, Cardiovascular
Infectious Disease	Surgery, General
Laboratory Tests	Surgery, Hand
Nephrology	Surgery, Plastic
Neurology	Surgery, Orthopedic
Nuclear Medicine	Surgery, Thoracic
OB/GYN	Surgery, Vascular
Orthopedic	Urology
Ophthalmology	Radiology (Ultrasounds, MRI, MRA, CT Scan, Nuclear Med Studies, Mammography (to include breast imaging or image guided biopsy) and x-ray procedures that are not done in the staff model clinics
Otolaryngology	Family Planning

Prior Authorization: Benefited services that must be authorized prior to provision of the service. These include the following:

Allergy & Immunology	Home health
Ambulance	Inpatient medical and mental health admissions
Bariatric related services	Occupational/speech therapy
Behavioral health and substance abuse outpatient services	Prosthetics
Cardiology	Pain Management
Clinical trials	Self –Injectables
Durable Medical Equipment	Specialty care referrals
Dermatology services	Surgical Procedures
Endocrinology	Transplant Related Services
Experimental/investigational services and new technologies	Direct Referral Specialty Care Beyond (1) One Visit

Standing Referrals: Authorization request for specialized care over a prolonged period for a life-threatening, degenerative or disabling condition.

PROCEDURES

I. Primary Care Providers' (PCP) Referral Responsibilities

A. If the PCP determines that a member requires specialty services or examinations outside of the standard primary care, the provider must request for these services to be performed by appropriate contracted providers. The provider must ensure the following steps in coordinating such referrals:

1. Submit a referral request to Seaside or the Primary Plan to obtain authorization for those services.

2. Seaside will process the request or contact the Primary Plan to obtain authorization for the facility component of services needed, as appropriate.

3. After obtaining the authorization(s):

    a. PCP/Seaside is responsible for notifying and referring the member to the appropriate specialist or facility.

    b. PCP, office staff, or member may arrange the referral appointment.

    c. PCP office notes the referral in the member's medical record and attaches any authorization paperwork.

    d. PCP discusses the case with the member and the referral provider.

    e. PCP receives reports and feedback from the referral provider regarding the consultation and treatment. (A written report must be sent to the PCP by the referral provider, or facility the member was referred to.)

    f. PCP Discuss the results of the referral, any plan for further treatment, and care coordination with the member, if needed.

        a. PCP serves as the medical case manager within each managed care system.

4. Referrals are tracked by the PCP's office and Seaside for follow-up through a tickler file, log or computerized tracking system. The log or tracking mechanism notes, at a minimum, the following for each referral:

    a. Member name and identification number
    b. Diagnosis
    c. Date of authorization request
    d. Date of authorization
    e. Date of appointment
    f. Date consult report received

5. The PCP is responsible in ensuring timely receipt of the specialist's report (e.g., use of tickler file). Reports for specialty consultations or procedures should be in the member's chart within two (2) weeks.

    a. If the PCP has not received the specialist's report within the determined timeframe, the PCP contacts the specialist to obtain the report.

    b. For urgent and emergent cases, the specialist should initiate a telephone report to the PCP as soon as possible, and a written report should be received within two (2) weeks.

II. Direct Referral Authorization

A. Service requests, as described above, are processed does not require review for medical necessity by the Utilization Management (UM) Department. Direct Authorizations apply to contracted and employed practitioners of Seaside.

B. The member's Primary Care Provider (PCP) fills out and indicates in the Direct Referral Authorization (DRA) Form the member's specialty service needs.

1. Member eligibility and Benefit Plan are checked for co-pay, exclusions and limitations;

2. The PCP keeps a copy of the DRA form at the member's chart in the PCP office;

3. A copy of the DRA form is provided to the member and another copy is sent to the specialist's office to assist the patient in making the appointment.;

4. The PCP office also sends a copy to Seaside UM Department.

C. The specialty service provider completes their designated part of the DRA form after the member's appointment and submits the form to Seaside for claims processing together with other required documentation based on the UM Program policy.

D. Direct Authorizations require tracking numbers rather than prior authorization.

III. Referral Submission

A. Referrals and requests for authorization are sent by providers to Seaside UM Department by mail, fax, plan provider portal or telephone. The request is checked for information including but not limited to:

1. Member name;

2. Date of birth;

3. Member ID number;

4. Social security number;

5. Requesting provider;

6. Referring provider;

7. Requested services, treatment, procedure, or test (CPT 4 code);

8. Facility/Vendor name;

9. Service site: inpatient, outpatient, office, ancillary vendor;

10. Duration and/or frequency of service:

a. Inpatient estimated length of stay;

b. Number of visits;

c. Number of months for DME rentals/use;

d. Medical Information to support the service request may include, but not be limited to: diagnosis; symptoms; duration of symptoms; previously tried treatments and effects/failures;

e. Lab, x-ray, imagery, diagnostic test results pertinent to the diagnosis, problem and service request;

f. Related functional impairments;

g. Diagnostic testing results, as appropriate.

B. If a referral or authorization request is submitted with insufficient medical information upon which to base a decision, additional information is requested.

1. The practitioner and member are notified of the delay in review and the reason for the delay. The delay/defer notice is sent via fax to the practitioner and mailed to the member.

IV. Referral Processing

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

B. 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.

C. 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.

D. Seaside ensures that upon receipt of the information, decisions to approve, modify, or deny requests by providers/practitioners is conducted in a timely fashion that is reasonably necessary to make the determination.

V. Referral Process Timeliness

A. Urgent Pre-Service Requests

1. Provider/practitioner and Member are notified within 24 hours of receipt of the request.

2. Decisions are made in a timely fashion as appropriate for the member's condition, not to exceed 72 hours of receipt of the request or not to exceed 48 hours of receiving all required information.

3. Provider/practitioner notified of decisions to approve, deny, delay, or modify health care services in writing within 24 hours of making the decision.

4. Member is notified of decisions to approve, deny, delay, or modify health care services in writing within 2 business days of making the decision.

5. If not enough information is initially received, practitioner/provider and member are provided 48 hours to submit requested information.

6. If requested information is received, complete or not, decision is made within 48 hours of receipt of additional information.

7. 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.

B. Non-Urgent Pre-Service Requests

1. Practitioner and Member are notified within 5 business days of receipt of the request.

2. 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).

3. Member and practitioner are provided at least 45 calendar days for submission of requested information.

4. If none of the requested information is received within 45 days or information received is incomplete, decisions are made within 5 business days of receipt of additional information or within 5 days after the 45 days deadline and no more than 15 calendar days if an expert reviewer is required.

5. Provider/practitioner notified of decision to approve, deny, delay or modify health care services in writing within 24 hours of making decision.

6. Member is notified decisions to approve, deny, delay, or modify health care services in writing within 2 business days of making the decision.

C. Urgent Concurrent Requests (e.g., inpatient, ongoing ambulatory services)

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.

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, the request is defaulted 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, the request is defaulted to the Non-Urgent Pre-Service category,

1. Care cannot be discontinued until the member's treating provider has been notified of the decision and a care plan has been agreed to by the treating provider.

2. Decision is made within 24 hours of receiving request.

3. The treating provider/s can readily access Seaside Physician that made the adverse decision via telephone.

4. Provider/practitioner is given notification of approval, denial, delay, or modification of health care services in writing within 24 hours of making the decision.

5. Member is notified in writing of approval, denial, delay, or modification of health care services within 24 hours of making the decision.

D. Post-Service Requests

1. Decision is made within 30 calendar days after Seaside's receipt of the information reasonably necessary and requested by Seaside to make the determination.

2. Provider/practitioner is given notification of approval, denial, delay, or modification of health care services in writing within 30 calendar days after Seaside's receipt of the information reasonably necessary and requested by Seaside to make the determination.

3. Member is notified in writing of approval, denial, delay, or modification of health care services within 30 calendar days after Seaside's receipt of the information reasonably necessary and requested by Seaside to make the determination.

4. Practitioner and member are provided at least 45 calendar days for submission of requested information.

5. 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).

E. Pended Referrals

1. If a decision to approve, modify or deny a referral cannot be made within the appropriate time frame, a pend notification will be sent to the practitioner and member in accordance with Seaside's timeframe policy.

2. Notification will include all of the following:

    a. 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 or type of expert reviewer;

    c. Time frame for submission of additional information;

    d. Expected date of decision;

    e. Physician reviewer's name and direct phone number;

    f. Notification of availability of translation and interpreter service;

3. Pended referrals will be tracked to ensure that decisions are made timely;

VI. Post Service Emergency Care

A. 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.

B. 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 medical treatment.

C. 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.

D. Emergency services criteria are utilized and denial decisions will take into consideration presenting symptoms and not be based solely on discharge diagnoses.

E. Requests cannot 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).

F. Emergency services are covered if an authorized representative, acting on behalf of Seaside, has authorized the provision of emergency services.

G. Seaside 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.

VII. Non-contracted or Unusual Specialty Services Provider Referrals

A. In order to ensure access to appropriate care, Seaside approves referrals to non-contracted providers or unusual specialty services when it's a covered benefit and is medically necessary when:

1. No similar or same contracted specialist and/or other provider is within Seaside and Primary Plan network.

2. Seaside UM staff assists with a member's transition to allow for continued care when benefits end, if necessary.

VIII. Referral Process for Behavioral Health Services

A. Authorizations for outpatient Behavioral Health services are processed by the UM Department.

B. Approved UM guidelines and criteria are applied and an authorization determination is made by appropriate mental health professionals. Approved guidelines include:

1. Milliman Care Guidelines, APA & ASAM criteria are used by Licensed Clinical Social Worker (LCSW), Psychologists and Psychiatrists

2. Automatic Authorization criteria are used by non-licensed staff.

C. Complex cases and those not meeting the criteria are reviewed by a doctoral level clinical psychologist or psychiatrist.

D. Requests for psychotherapy beyond 20 sessions are reviewed by a doctoral level clinical psychologist or psychiatrist.

E. Seaside Behavioral Health staff assists with the member's transition to other care, if necessary, when benefits end.

F. Seaside Behavioral Health staff follows policy and procedures related to continuity of care for new members meeting criteria of continuation of care

IX. Pended Referrals

A. If a decision to approve, modify or deny a referral cannot be made within the appropriate time frame, a pend notification will be sent to the practitioner and member in accordance with Seaside's UM Program timeframe policy

X. Referral Documentation

A. Referral requests, decisions, notifications and all pertinent related actions will be documented in the applicable UM file.

B. 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 appropriate resources (e.g., consultation with Health Plan, Health Plan criteria, medical policy).

C. 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.

D. Communications regarding decisions to approve requests by practitioners will specify the specific health care service approved.

E. 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.

History: New

Origination Date: May 17, 2013