

<b>HEALTH PLAN OF SAN JOAQUIN</b>		
<b>Subject:</b> AUTHORIZATION / REFERRAL POLICY		
<b>Department:</b> Medical Management		<b>Policy #:</b> UM01
<b>Applies to:</b> Medi-Cal, Healthy Families, Commercial		<b>Scope:</b> UM
<b>Effective Date:</b> 2/1/96	<b>Revised Date:</b> 1/08/09	<b>Approved by:</b> <i>QIUM Committee</i>

**Definition of Medical Necessity**

Medical Necessity is the reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

**POLICY**

- A. The Health Plan of San Joaquin (HPSJ) requires all covered services for physical conditions that require prior authorization, be submitted to the HPSJ Utilization Management (UM) Department for review for Medical Necessity.
- B. Mental Health services that require prior authorization will be submitted to the San Joaquin County Mental Health Service Department for review against mental and behavioral criteria for pre-authorization.
- C. Medical Criteria used to evaluate requests will be the current Milliman Care Guidelines, Medi-Cal (State of California) medical criteria.
- D. Only licensed health care professionals competent to evaluate the specific clinical issues involved in the health care services requested by the provider will have the authority to authorize, defer or modify requests.
- E. Only the Medical Director or Physician Designee will have the authority to deny requested services.

**PROCEDURE**

**A. Referral Process or Contracted Providers**

- 1. The PCP may refer his/her member to a **contracted network provider in San Joaquin County** for specialty consultation and up to two (2) follow-up using the following codes, without sending a copy of the referral to HPSJ.

<b>Type of Visit</b>	<b>CPT-Code</b>
Consultation	99241 through 99245
Outpatient Office Visits	99201 to 99205
Established Patient Visits	99211 - 99215

2. The PCP will use either the HPSJ Referral Form (RF) or a copy of the HPSJ on line Doctor's Referral Express (DRE) form when making a referral which will be sent to the specialist. The referral should include:
  - a) Brief history and accounting of the condition for which the member is being referred and any pertinent documentation or notes that could assist the specialist e.g.; x-rays, lab, medication history etc.
3. Claims will be paid to the specialist, without a copy of the referral being submitted, when above criteria (4.1.1) is met.
4. If the patients' condition requires continued follow-up visits or procedures, the specialist must submit a pre-authorization request to HPSJ UM department.

**B. Review Process**

1. **Services Requiring Pre-Authorization** – See (Attachment A) **Pre-Authorization**
  - a) The requesting physician will submit the pre-authorization request at least 5 or more days prior to the anticipated service date through DRE or fax to the HPSJ UM department for review.
  - b) The Referral Nurse will review the request and supporting documentation against the medical criteria within the timeframe specified in section 4.3 and a decision to approve, defer, modify or deny will be issued according to the review determination process under 4.4
  - c) Requested services that are seldom used, or contractors are not available within the contracted network, will be reviewed for appropriateness and authorized, if necessary, to a non-contracted provider with a letter of agreement (LOA) in place.

**C. Review Time-Frame**

1. **Emergent**
  - a) Requests that are submitted and marked as, emergent will be reviewed as a top priority and a decision rendered and the requesting provider notified **within 4 hours** based on the information submitted. However, **No pre-authorization is required for emergency treatment**, emergency

admissions and obstetrical deliveries. Emergency is defined acute medical or psychiatric symptoms that left untreated might be life threatening symptoms that left untreated could result in serious deterioration of a members health.

- The hospital must notify HPSJ of the admission as soon as possible, but not later than 24 hours following the emergency admission, or the next business day if the admission occurs on a weekend or holiday.

2. **Urgent /Request Pre-Authorization**

- a) The provider should submit the request marked as “URGENT” and the UM nurse will process the request within **3 working days**, provided all necessary information is submitted with which to make a determination. If approved, notification will be by phone, DRE, or faxed immediately to the requesting provider.
- b) Urgent request is defined as a member whose physical or mental condition is such that imminent or serious consequences could result to the member’s health if processed within the routine decision-making time frame.

3. **Routine**

- a) Routine pre-authorization requests will be processed within **five (5) working days** of receipt of all documentation from which to make a determination. A decision to approve, defer, modify or deny will follow the process for review determination in 4.4.

4. Concurrent review for services such as, pharmaceutical, inpatient stay in a hospital, skilled nursing facility or tertiary care center, will be reviewed and a decision made within 24 hours.

5. Retrospective review decisions will be within 30 working days of the receipt of information that is reasonably necessary to make the determination. The decision shall be communicated to the individual who received services, or to the individual’s designee, and the provider of services, within 2 days of the decision.

D. **Review Determination**

1. **Approval**

Approval will be based on benefit criteria and medical necessity as demonstrated in the documentation submitted by the requesting provider and reviewed against Milliman Care Guidelines or Medi-Cal medical guidelines.

2. **Deferral**

The Referral Nurse will defer and hold the request for up to 25 days when:

- a) Specific information needed to make a determination is missing and is requested from the provider and;

- b) Justification for requesting the additional information is in the members' interest, or,
- c) When the member or member's provider requests an extension, after the request has been submitted.
- d) The Medical Director requests a consultation by an expert reviewer
- e) The Medical Director requests additional testing or specialty examination prior to making a decision.
- f) Any decision delayed beyond the 25-day time limit is considered a denial and will be processed as such.

**Deferral Process:**

- The Referral Nurse will first contact the requesting provider to request specific information needed for the review.
  - If no response within 5 days, a letter notifying the provider and the member, that a decision to approve, cannot be made and the reason for the delay. The letter will indicate the number of days the request will be held and the anticipated date on which a decision may be rendered.
  - If after an additional 25 days, information requested has not been received, a denial letter will be issued.
  - For the Healthy Families members, a copy of the right to request an Independent Medical Review (IMR) will be included in the letter.
- g) For Urgent requests the deferral time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Medical Director can justify the need to extend the review period while waiting for requested medical information.
  - h) Upon receipt of the requested information, HPSJ will follow the standard review timeframe for making the determination to approve, or deny the request.
  - i) HPSJ does not honor the "date received" stamped on an incomplete pre-authorization request when returned or deferred for more information. No action is taken until the pre-authorization is returned to HPSJ with the requested information. The date returned to HPSJ review box is the date used in determining if appropriate review turn-around timelines have been met.

**3. Denial**

Denials will be made by the Medical Director or the Physician Designee and will be based on lack of medical necessity, and/or failure to meet the medical review criteria. Notification of a denial will go out to the provider and member within 2 working days of the decision.

- a) When a denial determination is issued, the Medical Director or Physician Designee will document the reason used to make the determination and will then send the request to the UM staff to:
    - Prepare the appropriate letter to go to the provider and member **within 2 working day** of the decision to deny.
    - The letter includes the member’s right to appeal.
    - For the Healthy Families members, a copy of the right to request an Independent Medical Review (IMR) will be included in the letter Provide a copy of the criteria used to make the determination.
4. Reports and Oversight
- a) The Turn-around-time for routine, urgent and emergent report (TAT) will be run monthly to evaluate the adherence to contract standards and will be reported to the QIUM Committee semi-annually or when compliance of the Turn Around Time (TAT) becomes an issue.
  - b) Inter-rater Reliability Studies to determine UM staff capabilities to conduct specific job duties within their specific level of practice will be performed quarterly.
  - c) Aggregate over/under utilization data analysis will be conducted by HPSJ’s Medical Management Department. This review is designed to identify individual provider practice patterns relative to standards of medical practice to evaluate over and under utilization of services.

**REFERENCE**

- A. Health and Safety Code Section 1367.01
- B. Health and Safety Code Section 1363.5
- C. Title 22 Section 53261
- D. Title 22 Section 53857
- E. DHS Contract Exhibit A, Attachment 5
- F. HPSJ Policy and Procedure UM06 Medical Review Criteria
- G. HPSJ Policy and Procedure UM07 Notification of denial, defer, modify
- H. HPSJ Policy and Procedure UM 19 Mental Health Benefits for Commercial
- I. HPSJ Policy and Procedure UM 49 Mental Health Benefit for Medi-Cal

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