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# SECTION 8: UTILIZATION MANAGEMENT

## UTILIZATION MANAGEMENT PROGRAM OVERVIEW

HPSJ has Utilization Management (UM) policies and procedures that support the provision of quality health care services. The goal of UM is to provide Members with the right care, in the right venue, within the most appropriate timeframe. The UM program staff can provide guidance to Providers in order to help support care in all clinical settings and situations including acute care, Long Term Acute Care, Emergency situations, ancillary support, and Hospital admissions for both acute and psychiatric diagnoses.

The key objective of HPSJ's UM Program is to improve access to care, maintain the highest quality, and create healthy outcomes while providing the most cost effective care possible.

## COUNSELING MEMBERS ON TREATMENT OPTIONS

Every Provider has the responsibility of counseling Members as to the course and options in medical treatment regardless of whether it is a covered benefit or not. The UM Department will assist and provide case and/or disease management services for Members at risk for substantial health costs or ongoing care. The UM Department will also assist in establishing whether the Member is eligible for other medical programs available through the State or in the local community.

## AVAILABILITY OF MEDICAL REVIEW CRITERIA

UM routinely conducts timely prospective, concurrent, and retrospective review of requested care and Covered Services. Authorization determinations are made by licensed clinical staff and are based on plan eligibility and benefit coverage, as well as medical necessity using evidence-based and industry standard medical guidelines. At any time a provider may request a copy of criteria used to make medical necessity decisions during the utilization review process by calling the Health Plan of San Joaquin at (888) 936-7526. Appropriately licensed professionals supervise and monitor all Authorization decisions. Authorization denials are Peer Reviewed by a physician or pharmacist, as appropriate. Competence is determined by appropriate training, experience, and/or certification by the American Board of Medical Specialties.

For non-emergency services, hospitals must contact the Plan for prior authorization before services are rendered. For emergency services that result in admission, hospitals must contact the Plan within 24 hours or the next business day for authorization. If a patient is seen in the ER and admitted, the case must still meet admission criteria based on medical necessity review to be authorized and covered by the Plan. If a patient is seen in the ER and held for observation, but not admitted, observation services will only be paid if indicated for up to 48 hours as an outpatient service.

A hospital can appeal any claim denial or administrative action. However, failure to obtain proper

timely authorization, regardless of medical necessity, is a reason for denial, if there are no other extenuating circumstances.

## UTILIZATION MANAGEMENT STAFF AVAILABILITY

Providers are encouraged to contact HPSJ's Utilization Management Staff and the Medical Directors to discuss referrals, Case Management of specific Members, or other areas of concern.

### UM Staff Availability during Normal Business Hours

HPSJ UM staff members are available Monday through Friday from 8:30 am to 5:00 pm to receive and respond to inquiries regarding UM issues from Members and Providers. UM staff members can be reached at (209) 942-6320 or (888) 936-7526. Providers can also contact the Intake Processor of the Day (IPOD) located on DRE who can assist with Authorizations or questions. The phone number to reach the Medical Director regarding a UM issue is (209) 942-6353.

### UM Staff Availability After Hours

Providers who need assistance after normal business hours may leave a secure voice mail message by calling (209) 942-6320 or (888) 936-7526. All voice mail messages are retrieved each business day at 8:00 am by a Customer Services Representative who responds to the call or routes the message to the appropriate UM staff member. Responses to voice mails are returned no later than the next business day.

## REFERRALS TO IN-NETWORK/OUT OF NETWORK PROVIDERS

HPSJ maintains a wide network of Providers to ensure that the majority of health care needs can be provided within the Service Area. Providers are best prepared to accept referrals and operate within parameters established by HPSJ. These Providers also meet the standards for timely and geographic access for our Members. If Providers are experiencing difficulty in locating a local Provider that can meet the Member's medical needs, they should contact the UM Department at (209) 942-6320.

In some cases HPSJ may have exclusive contracts with specialty Providers. In these instances, referrals must be directed to these Providers. Currently all laboratory, all behavioral health, and some vision and durable medical equipment services are contracted through specific vendors. For more information on referral providers please contact the UM Department at (209) 942-6320.

In the event Covered Services are needed from an out-of-network provider, the UM Department should be contacted at (209) 942-6320 in order to obtain approval for a referral. HPSJ's Contracting Department will contact providers that may be available to meet the clinical needs of the Member.

## OBTAINING A SECOND OPINION

HPSJ honors the Member's right to obtain a second opinion from another Provider. To coordinate this, the Member should be directed to an in-network Provider. The UM Department will evaluate the request and make arrangements for the consultation. If an in-network Provider is unavailable, Authorization for an out-of-network second opinion will be made. The UM Department will also notify the Member and the originating Provider in writing of the results of the consultation.

## COVERED SERVICES THAT DO NOT NEED PRIOR AUTHORIZATION/REFERRAL

HPSJ permits a Member to obtain some Covered Services without a referral or prior Authorization. A complete list of these Covered Services can be found on DRE and should be regularly reviewed for changes.

However, the following Covered Services never need a referral from a Provider. Members may choose an in-network Provider or an out-of-network provider for:

- Emergency Services
- Certain preventative services (Access DRE for more information)
- Basic prenatal care
- HIV testing
- Family Planning
- Treatment and diagnosis of STDs
- Sensitive services for both men and women
- Well women health service

## AFFIRMATIVE STATEMENT ON INCENTIVES

HPSJ's UM decision making is based solely on appropriateness of care, service, and existence of coverage. HPSJ does not specifically reward any Provider or other individuals for issuing denials of coverage. Financial incentives for UM decisions do not in any way encourage decisions that result in underutilization.

## SUBMITTING REQUESTS FOR AUTHORIZATIONS

Providers should always first verify the Member's eligibility through Doctor's Referral Express (DRE) before submitting a referral for Authorization for Covered Services. Information on other methods to verify a Member's eligibility is detailed in this Manual under "Eligibility Verification, Member Enrollment, and Customer Services." The Authorization Request Form is available online

in DRE or can be submitted by fax. To ensure prompt response to Authorizations, it is preferable to submit the Authorization online through, DRE.

In completing the form, the following information is required:

- Member's demographic information (name, date of birth, etc.)
- Request type (Office Based or Facility)
- Requester
- Requester affiliation or "Pay To Service"
- Provider's National Provider Identifier (NPI) (only required for paper submissions)
- Provider Group's NPI ( if there is a Group NPI; only required for paper submissions)
- Provider's tax ID number (only required for paper submissions)
- Location where services will be provided
- Requested service/procedure, including specific CPT/HCPCS codes
- Member diagnosis (ICD code and description)
- Modifiers, if applicable
- Fax back number
- Clinical indications necessitating service or referral
- Pertinent medical history and treatment
- Medical records and/or other documents supporting the request
- Supporting clinical documentation (Clinical information can be scanned and uploaded directly into DRE along with the Authorization request.)

## ADVANTAGES OF SUBMITTING AUTHORIZATIONS ONLINE VS FAX

Providers can submit referrals online through DRE or by fax. Online is the preferred method, because it has two very important advantages:

- By submitting referrals online, Providers have immediate access to the status of the referral. Authorization status is not immediate or may be delayed when the referral is faxed.
- By submitting referrals online, Providers can communicate directly with HPSJ staff via DRE regarding any aspect of the Authorization status.

## TURNAROUND TIME FOR PRIOR AUTHORIZATION

The turnaround time for a prior Authorization depends on the status of the request:

- **Urgent Request**: Within seventy-two (72) hours of receipt of Authorization request
- **Routine Request:** Within five (5) Working Days of receipt of Authorization request.
- Prompt Authorization determinations are made in accordance with these guidelines when all supporting clinical information that supports medical necessity is submitted along with the Authorization request.

## EMERGENCY/URGENT CARE SERVICES

Emergency Services are available at any time without any prior Authorization. HPSJ does not deny claims for Emergency Services including screening (triage) even when the condition does NOT meet the medical definition of "Emergency Services". Hospitals, urgent care centers, and professional services (including labs, ancillary services, etc.) cannot bill, charge, or collect money from any Member for any Emergency or Urgent Care Services. PCPs should counsel Members if they are using hospital Emergency Services for routine, non-Emergency medical conditions.

As appropriate, Members should use urgent care facilities for urgent non-Emergency conditions. HPSJ has contracted with urgent care centers throughout the Service Area and they offer both convenient hours and, in most cases, shorter waiting times than Emergency Rooms.

## INPATIENT ADMISSIONS

All inpatient admissions to acute care facilities, skilled nursing facilities, or Long Term Acute Care facilities require prior Authorization except in the case of an Emergency. Providers are required to obtain prior Authorization for an elective admission. Providers are also required to admit Members only to Hospitals contracted with HPSJ. Elective admissions to out-of-network facilities will require prior Authorization.

## INPATIENT CONCURRENT REVIEW

To ensure that both quality and cost-effective inpatient care is provided to Members, it is imperative that Members receive the appropriate level of care while they are in the inpatient setting. HPSJ's goal is a safe, efficient Member discharge from inpatient facilities. When Members are admitted to an inpatient facility, the Member's care is reviewed by a Concurrent Review Registered Nurse (CCRN) to ensure that the Member is receiving both quality and cost-effective inpatient care at the appropriate level of care. This applies if Member receives care in an acute, rehabilitation, skilled, or other inpatient facility. To ensure HPSJ is notified of admission, facility is required to fax member face sheet to the Utilization Management (UM) department within 24 hours. The CCRN's objective is to successfully coordinate Member's medical care while in an inpatient facility. This requires a team approach between the facility staff and the CCRN. To achieve this objective, the CCRN or the Medical Director may need to contact the Attending

Physician. It is essential that timely and accurate communication occurs between facility care management staff, the Attending Physician, and the HPSJ UM staff.

HPSJ's physicians and other licensed clinical staff apply national standards of care (*Milliman Care Guidelines*) to determine the medical necessity for the inpatient stay and the level of care, namely, acute medical-surgical, telemetry, intermediate or intensive care unit level of care. If the medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the inpatient stay or for the level of care requested, the inpatient stay will be denied by the Medical Director.

The Facility and Provider are provided the reason for the denial and the appeal rights. If the level of care that is delivered to the Member is deemed inappropriate, the level of care billed by a facility is subject to denial.

## NEW MEDICAL TECHNOLOGY

The use of new medical technology needs prior Authorization, which will be provided on a case by case review by HPSJ professional medical staff. All requests must be submitted to HPSJ with documentation prior to implementation of the treatment plan.

## MAJOR ORGAN/TISSUE TRANSPLANTS

Currently, only cornea and kidney transplants are covered benefits for Members. Other transplants however are a covered benefit under Medi-Cal Fee for Service. Members needing other types of transplant services can be disenrolled and subsequently re-enrolled into the Medi-Cal fee-for-service program. Once the Member begins the transplant process, all providers will be paid fee-for-service. The Member returns to HPSJ one year post transplant. To initiate this process, contact the UM Department at (209) 942-6320.

## INITIAL HEALTH ASSESSMENTS

Within one hundred twenty (120) days of the date of Enrollment, PCPs must perform an Initial Health Assessment (IHA) on new Members. This includes a *Staying Healthy Assessment*, which is a DHCS approved Individual Health Education Behavioral Assessment (IHEBA) tool. The IHA includes a complete physical exam: examination to assess the Member's current acute, chronic, and preventive health needs, a full medical history, and an assessment of health behaviors. Also included is a dental screening and oral assessment for children under age three (3) years old, including a referral to a dental provider if needed. Immunizations, including documentation of all age-appropriate immunizations in the Member's medical record and the screening for tuberculosis are also included. HPSJ allows separate billing for many of these services when provided under capitation.

DHCS Requires PCPs to administer an Individual Health Education Behavioral Assessment

(IHEBA) as part of the IHA for new Members and for subsequent well care visits for current Members. The *Staying Healthy Assessment* is an assessment tool that is used to administer the IHEBA. This form is accessible on the DHCS's website at www.dhcs.ca.gov.

# ADULT PREVENTATIVE GUIDELINES

| | 21 to 39 | 40 to 49 | 50 to 65 | 65 + |
|---|---|---|---|---|
| **History and Physical** | | | | |
| Initial Health Visit | Within 120 days of Enrollment | | | |
| History & Physical Exam | Every 1 to 3 years | | | Every Year |
| Blood Pressure, Weight, & Height Check | With every history & physical | | | |
| "Staying" Healthy Assessment | Every 3 to 5 years | | | |
| Vision, Hearing & Dental Exam | With referral | | | |
| Digital Rectal Exam | None | With every history & physical | | |
| **Labs & tests** | | | | |
| Ultrasound for Abdominal Aortic Aneurysm | | None | | *See below |
| Fecal Occult Blood | None | | Every Year | |
| Sigmoidoscopy | None | | Every 3 to 5 years | |
| Colonoscopy | None | | Every 10 years | |
| Cholesterol Screening | As needed | | | |
| TB Screening | For high risk Members, health care workers, & Members leaving country | | | |
| Hepatitis C Screening | None | | At least one time if born between 1945 & 1956 | |
| Chlamydia | Every year if high risk | | None | |
| HIV & Other STDs | Based on risk assessment | | | |
| **Immunizations** | | | | |
| Influenza | Every Year | | | |
| Tetanus, diphtheria, pertussis (Tdap) | 1 dose with booster every 10 years & 1 dose in 3rd trimester of each pregnancy | | | |
| Shingles (Zoster) | None | | | |
| Pneumococcal | 1 dose | | | 1 dose |
| Meningococcal | 1 or 2 doses | | | |
| Measles, mumps, rubella (MMR) | 1 or 2 doses | | | None |
| Human papillomavirus | Women: 3 doses 19 to 26 years Men: 3 doses 19 - 21 years & 22 - 26 years | None | | |
| Chickenpox (Varicella) | 2 doses | | | |
| Hepatitis A | 2 doses | | | |
| Hepatitis B | 3 doses | | | |
| Haemophilus infuenzae type b (Hib) | 1 or 3 doses | | | |
| **For Women** | | | | |
| Pelvic Exam | 1 to 3 years | Every Year | | |
| PAP | 1 to 3 years** | | | None |
| Mammogram & Breast Exam | | Every year | | |
| Bone density test | None | | | Once |

Change in recommendations at age

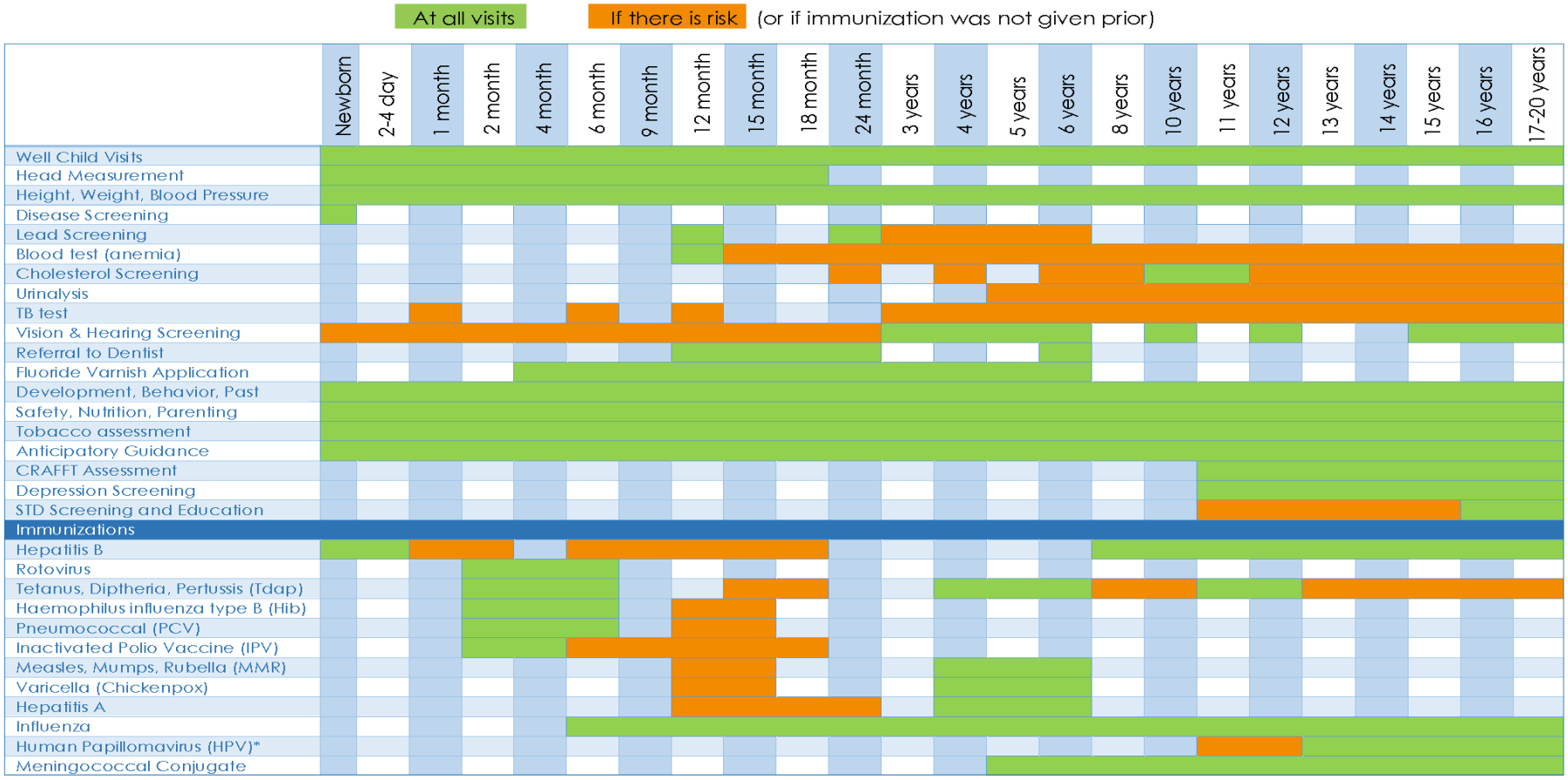
*At 65 with history of smoking/tobacco use, to be completed only once.
**Every 3 years if low risk (history of 2 normal PAP smears) Annual PAP if on birth control

Source CDC Immunization Schedule and American Academy of Family Physicians



Health Plan of San Joaquin

## PEDIATRIC PREVENTIVE GUIDELINES




Source: CDC Immunization Schedules for all Ages. Periodicity Schedule, American Academy of Pediatrics. This material can be provided in larger font and/or other languages. Please call (888) 936- PLAN (7526)
*All 11 or 12 year olds – both girls and boys – should receive 3 doses of HPV vaccine to protect against HPV-related disease. The full HPV vaccine series should be given as recommended for best protection.

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## CALIFORNIA HEALTH AND DISABILITY PROGRAM (CHDP)

Providers seeing children less than twenty-one (21) years of age must participate in CHDP. CHDP is Medi-Cal's comprehensive and preventive child health program for individuals. Recipients receive periodic health screening exams required by the federal Medicaid "*Early and Periodic Screening, Diagnostic and Treatment"* mandates in California. Corrective treatment resulting from child health screenings must be arranged even if the service is not available to the rest of populace. The HPSJ Utilization Management team will assist Providers in such arrangements.

The following minimum elements are included in the periodic health screening assessment:

- Comprehensive health and development history (including assessment of both physical and mental development
- Comprehensive unclothed physical examination
- Immunizations appropriate to age and health history
- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
- Dental screening and services
- Hearing screening and services, including at a minimum diagnosis and treatment for defects in hearing, including hearing aids
- Appropriate behavioral health and substance abuse screening
- Health education, counseling, and anticipatory guidance as the child develops

### Vaccines for Children (VFC)

VFC is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of their inability to pay. CDC buys vaccines at a discounted rate and distributes them at no charge to those private physicians' offices and public health clinics registered as VFC providers. Children enrolled in HPSJ are eligible for free vaccines. Providers are paid for administering the vaccines. Please see the section in this Manual on "Claims and Billing" for billing instructions.

## CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Children with Special Health Care Needs (CSHCN) are defined by DHS as: "those who have or are at increased risk for a chronic, physical, behavioral, developmental, or emotional condition and who also require health or related services of a type or amount beyond that required by children generally."

HPSJ is committed to assuring that all Medically Necessary screening, preventative, and therapeutic services are provided to Members with developmental disabilities. PCPs and/or referral Specialists are responsible for identifying Members with potentially eligible conditions and subsequently referring those Members to appropriate programs for genetically handicapped persons. Valley Mountain Regional Center (VMRC) is the primary referral source for HPSJ's Service Area.

## DEVELOPMENTAL DISABILITIES SERVICES (DDS)

A developmental disability is a disability which originates before an individual reaches eighteen (21) years old, continues or can be expected to continue indefinitely, and which constitutes a substantial disability for that individual. This term includes but is not limited to developmental delay, cerebral palsy, epilepsy, autism, and disabling conditions, but exclude other handicapping conditions that are solely physical in nature.

As part of the initial health assessment and routine health assessment (which will be done according to the American Academy of Pediatrics Periodicity Schedule), the PCP will identify individuals with significant developmental delay or those at risk for developmental disability and make the appropriate referral to Beacon Health Options. The following information must be included:

- Reason for the referral
- Complete medical history and physical examination, including appropriate developmental screens
- Results of developmental assessment/psychological evaluation and other diagnostic tests as indicated

## CALIFORNIA CHILDREN'S SERVICES (CCS)

California Children's Services (CCS) is a State program for children with certain diseases or health problems. The CCS program provides health care services, including diagnostic, treatment, dental, administrative case management, physical therapy, and occupational therapy services, to children from birth up to twenty-one (21) years of age with CCS-eligible medical conditions. Examples of CCS-eligible medical conditions include, but are not limited to: cystic fibrosis, sickle cell anemia, hemophilia, cerebral palsy, heart disease, cancer, infectious diseases producing major sequelae, traumatic injuries, and handicapping malocclusion. Applicants must meet age, residence, income and medical eligibility requirements to participate in the CCS program. Medically Necessary services to treat a child's CCS-eligible medical condition are "carved out" of HPSJ's financial responsibility. This means that HPSJ is not financially responsible for reimbursing Providers for services to Members who qualify for CCS-eligible services.

The CCS program requires authorization for health care services related to a child's CCS-eligible medical condition. HPSJ Providers must bill CCS instead of HPSJ for CCS-eligible services by submitting Service Authorization Requests (SARs) to a CCS county or State office, except in an Emergency.

To render CCS-eligible services to a Medi-Cal patient and to receive reimbursement from CCS, any provider must be CCS paneled and the facility must be a CCS certified facility. During the interim, between the submission for the child to become enrolled in CCS, Providers must continue to provide care to the Member either under capitation or fee-for-service depending upon the Provider's Agreement. CCS is in place to help Providers care for Member's with special health care needs. For more information about the CCS program, please visit the CCS website at www.dhcs.ca.gov.

Referrals to CCS are accepted from any source, health professionals, parents, legal guardians, school nurses, HPSJ, etc. Referral forms are available on the HPSJ, Medi-Cal, or CCS websites.

The following is a list of CCS conditions which are typically covered by CCS.

- AIDS
- Cancer
- Cataracts
- Cerebral palsy
- Chronic kidney disease
- Cleft lip/palate
- Congenital heart disease
- Diabetes
- Hearing loss
- Hemophilia
- Intestinal disease
- Liver disease
- Muscular Dystrophy
- Rheumatoid arthritis
- Seizures
- Severe burns
- Sever crooked teeth
- Severe head, brain or spinal cord injuries
- Sickle cell anemia
- Spina bifida
- Thyroid conditions
- Tumors

## FAMILY PLANNING SERVICES

Members may obtain family planning services from their PCP or a Specialist on HPSJ's panel of Providers without prior Authorization or a referral. Members can also obtain these services by going outside of HPSJ's network to any family planning provider or provider of Sensitive Services without a referral or Authorization.

This out-of-network provision is without any restrictions.

## SENSITIVE SERVICES FOR ADOLESCENTS AND ADULTS

Sensitive Services are services that require some form of confidentiality in the way services are provided and the way medical records are disclosed for all Medi-Cal members. These services must be administered with the following guidelines in mind:

- Sensitive Services are provided in confidence to adolescents and adults without barriers (e.g., can't require parental consent)
- Authorization for Sensitive Services is not required
- Adult Members may self-refer without prior Authorization for Sensitive Services except in cases where those services require hospitalization
- Parental consent for children twelve (12) years and older is not required to obtain Sensitive Services
- Providers will not at any time inform parents or legal guardians of a minor's Sensitive Services care and information without minor's permission, except as allowed by law

HPSJ provides access without prior Authorization or referral to any in-network Provider or out-of-network provider that a Member may select to provide Sensitive Services.

Sensitive Services include but are not limited to consultations, provision of supplies or medical devices, examinations, education and treatment related to:

- Family Planning
- Pregnancy Testing
- HIV Testing and Counseling
- Sexually Transmitted Diseases
- Elective Abortions
- Behavioral Health Services

## FACILITY/ANCILLARY REFERRALS AND AUTHORIZATIONS

### Hospital Authorizations

Facility referrals for elective Inpatient Service must be prior Authorized by HPSJ. After the Member is admitted to the facility, the admitting Provider, including any hospitalists, will manage the Member's treatment and care. Admissions to out-of-network facilities require approval of the Medical Director.

HPSJ uses *Milliman Care Guidelines* to assist in determining length of stay and treatment options. It is imperative that the Facility team and HPSJ work together for the clinical benefit of the Member, but also for clarity in determining claims payment.

### Hospital Emergency Admissions

The Emergency admission of a Member to any Facility must be reported to HPSJ within twenty-four (24) hours. This reporting must be followed with a detailed summary of the Member's clinical condition, options, and prognosis for treatment. This report must clinically demonstrate the need for inpatient treatment. Without this clinical information, HPSJ may deny the admission as not Medically Necessary. Once the clinical information is received and reviewed by HPSJ, the admission may be Authorized, denied, or pended for additional information.

### Outpatient and Ancillary Referrals

Providers should consult DRE for guidance on referrals for outpatient and ancillary services. For Covered Services requiring Authorization, the requesting Provider will be notified of HPSJ's decision to Authorize or deny. Upon Authorization HPSJ will coordinate with contracted outpatient and/or ancillary Providers. Ancillary services are routinely limited to the Medi-Cal guidelines for ancillary benefits.