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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 place, within the most appropriate timeframe. The UM program staff can provide guidance to Providers to help support care in all clinical settings and situations including hospital admissions (both medical and psychiatric diagnoses), Long Term Acute Care, emergency situations, ancillary support, and Long-Term Care.

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 care coordination, case and/or disease management services for members at risk for substantial 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

The UM department conducts timely prospective, concurrent, and retrospective review of requested care and services. Licensed clinical staff evaluate treatment requests ensuring that services are medically necessary and congruent with evidence-based, nationally recognized clinical 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. Only a physician with appropriate training, experience, and certification by the American Board of Medical Specialties, or a licensed pharmacist may defer, modify or deny a request for services based on medical necessity.

INPATIENT CARE

HPSJ uses nationally recognized, evidence-based clinical guidelines, including but not limited to MCG, to guide medical necessity review for admission, length of stay and treatment options. It is imperative that the Facility team and HPSJ work together for the clinical benefit of the Member, discharge planning and transitions of care coordination, and for clarity in claims processing.

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SECTION 8: UTILIZATION MANAGEMENT

Contracted Hospitals

Planned (elective) admissions
The admitting physician or hospital must obtain authorization from HPSJ prior to the member's admission. Prior authorization requests are processed within 5 business days of receipt of the request and supporting clinical documentation reasonably necessary to make a decision, or in the case of an urgent request, within 72 hours of receipt of the request and documentation. If additional information is needed, the decision may be deferred, and the time limit extended an additional 14 calendar days Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. Requests may be submitted online through the Provider Portal Doctor's Referral Express (DRE) at www.hpsj.com/providers, or by fax at 209-942-6302. See section 8, page 5 of this manual for additional information.

Observation
If a patient is seen in the ER and held for observation (not admitted), observation services are paid per the contracted rate for up to 24 hours. Observation services beyond 24 hours require notification and clinical documentation to support medical necessity, which should be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 209-762-4702. See section 8, page 6 of this manual for additional information.

Emergency Admissions
If a patient is seen in the ER and admitted for stabilization and further treatment, no authorization is required for services required to stabilize the member. The hospital must, within one business day after admission, notify and provide clinical documentation to support medical necessity of ongoing inpatient services, which should be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 209-762-4702.

Post Stabilization
If a member is seen in the ER for an emergency condition and is stabilized*, but admission is recommended for additional medically necessary care, the hospital must, within one business day, notify and provide clinical documentation to support the medical necessity of continued inpatient care, which should be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 209-762-4702. The requests are processed within 72 hours from receipt of the request and supporting clinical documentation reasonably necessary to make a decision.

Continued Stay (Concurrent) Review
If a member requires additional inpatient services beyond the approved length of stay, the hospital must provide updated clinical documentation to support the medical necessity of continued inpatient care. Requests may be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 209-762-4702. The requests are processed within 72 hours from receipt of the request and supporting clinical documentation reasonably necessary to make a decision.

* A patient is stabilized, or stabilization has occurred when, in the opinion of the treating provider, the patient`s medical condition is such that, within reasonable medical probability, no material deterioration of the patient`s condition is likely to result from, or occur during, the release or transfer of the patient. California Health And Safety Code Section 1317.1, Section (j

Non-Contracted Hospitals

Planned (elective) admissions
The admitting physician or hospital must obtain authorization from HPSJ prior to the member's admission. Prior authorization requests are processed within 5 business days of receipt of the request and supporting clinical documentation reasonably necessary to make a decision, or in the case of an urgent request, within 72 hours of receipt of the request and documentation. If additional information is needed, the decision may be deferred, and the time limit extended an additional 14 calendar days Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. Requests may be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 209-942-6302. See section 8, page 5 of this manual for additional information.

Emergency Admissions
If a patient is seen in the ER and admitted for stabilization and further treatment, no authorization is required for services required to stabilize the member. The hospital must, within one business day after admission, notify and provide clinical documentation to support medical necessity of ongoing inpatient services, which should be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 209-762-4702.

Post Stabilization
If a member is seen in the ER for an emergency condition and is stabilized*, but admission is recommended for additional medically necessary care, the hospital must contact HPSJ at **209-461-2205** to obtain authorization for post stabilization care.

Clinical information needed by HPSJ includes the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary to make a decision in authorizing or assuming management of the patient's care by prompt transfer to a network hospital provided. The clinical information may be provided either verbally or by fax at 209-762-4702, at HPSJ's discretion.

HPSJ shall not require a non-contracted hospital representative, physician, or surgeon to make more than one telephone call to HPSJ. The representative of the hospital may be but is not required to be a physician and/or surgeon. When HPSJ is contacted by a non-contracted hospital, within 30 minutes from the time of the initial contact, HPSJ shall either authorize post stabilization care or inform the noncontracting hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

Continued Stay (Concurrent) Review
If a member requires additional inpatient services beyond an approved length of stay, the hospital must provide updated clinical documentation to support the medical necessity of continued inpatient care. Requests may be submitted online through the Provider Portal (DRE) at www.hpsj.com/providers, or by fax at 209-762-4702. Requests are processed within 72 hours from receipt of the request and supporting clinical documentation reasonably necessary to make a decision.

* A patient is stabilized, or stabilization has occurred when, in the opinion of the treating provider, the patient`s medical condition is such that, within reasonable medical probability, no material deterioration of the patient`s condition is likely to result from, or occur during, the release or transfer of the patient. California Health And Safety Code Section 1317.1, Section (j)

SECTION 8: UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT STAFF AVAILABILITY

Providers are encouraged to contact HPSJ's Utilization Management Staff and the Medical Directors to discuss referrals, case management services for specific members, or other areas of concern.

UM Staff Availability during Normal Business Hours

HPSJ UM staff members are available Monday through Friday from 8:00 am to 5:00 pm pacific time 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 the Provider Portal who can assist with Authorizations or questions. The phone number to reach the Medical Director regarding an UM issue is (209) 942-6353.

UM Staff Availability After Hours

Non-Contracted hospitals who need urgent authorization for admission may call 209-461-2205 24 hours/day, 7 days/week. Providers who need assistance with routine matters may leave a secure voice mail message after normal business hours at (209) 942-6320. 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 most health care needs can be provided within the Service Area. These Network Providers are best prepared to accept referrals and operate within the guidelines 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 to providers please contact the UM Department at (209) 942-6320.

If 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 the referral. HPSJ's Contracting Department will contact providers that may be available to meet the clinical needs of the Member.

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CONTINUITY OF CARE

HPSJ provides continuity of care for members when their provider is no longer part of the network or when the member is transitioning from Medi-Cal fee-for-service (FFS) to HPSJ or from another managed care plan to HPSJ, upon request. HPSJ members can continue to see their non- contracted provider for up to 12 months when:

- Member has an existing relationship with the provider
- Provider accepts HPSJ's reimbursement rate or Medi-Cal FFS rate
- Provider is in good standing and does not have any disqualifying quality of care issues
- Provider is a California State Plan provider
- Provider supplies HPSJ all relevant treatment information

Continuity of Care does not apply for services not covered by Medi-Cal, or DME, transportation, other ancillary services, or carved-out service providers.

If you are a contracted provider providing services to an HPSJ member, you may initiate a request for continuity of care through the provider portal, Medical Authorization Form available on the HPSJ website at www.hpsj.com, or by contacting Customer Service at (209) 942-6320 or (888) 936-7526.

If you are a non-contracted provider providing services to an HPSJ member, you may initiate a request for continuity of care by submitting a Medical Authorization Form avaialble on the HPSJ website at www.hpsj.com or by contacting Customer Service at (209) 942-6320 or (888) 936-7526.

OBTAINING A SECOND OPINION

HPSJ honors the Member's right to obtain a second opinion from another Provider when indicated. To coordinate this, the Member should be directed to an in-network Provider. If an in-network Provider is unavailable, Authorization for an out-of-network second opinion should be requested. The UM Department will notify the Member and the originating Provider in writing of the result of the authorization request, and assist with making arrangements for the second opinion upon request.

HPSJ will allow a second opinion to members by an appropriately qualified healthcare professional, if requested by a member or a participating provider who is treating the member. An authorization is not needed for a second opinion with an in-network provider. If the provider is out of network an authorization is needed. HPSJ will also arrange transportation if needed for the second opinion.

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 the Provider Portal 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 the Provider Portal for more information)
- Basic prenatal care in-network
- HIV testing
- Family Planning
- Treatment and diagnosis of sexually transmitted diseases (STDs)
- Sensitive services for both men and women
- Well women health service

STANDING/EXTENDED REFERRALS

Health Plan of San Joaquin (HPSJ) Primary Care Providers (PCP) may request a standing or extended access referral to a non-network Specialist for a member who has ongoing specialty care needs. HPSJ will refer members to contracted specialists unless there is no specialist within the plan network that is appropriate to provide treatment to the member, as determined by the primary care physician in consultation with the planned medical director as documented in the treatment plan. When a standing or extended access referral is medically necessary and there is no appropriate network specialist to provide treatment to the Member, the standing or extended referral will be approved to an out of network Specialist for up to 12 months.

Conditions necessitating a standing or extended access referral and/or the development of a treatment plan are interpreted broadly as a “condition or disease that requires specialized medical care over a prolonged period of time and as life threatening, degenerative or disabling” and could include but are not limited to the following:

- Hepatitis C
- Lupus
- HIV/AIDS
- Cancer
- Potential transplant candidates
- Severe and progressive neurological condition
- Renal failure
- Cystic fibrosis

- Acute leukemia
- High risk pregnancy

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 must verify a Member's eligibility before submitting a referral for Authorization for Covered Services. Eligibility may be verified through the Provider Portal located in the Provider area of the HPSJ website (www.hpsj.com). Alternate methods to verify eligibility are detailed in this Manual under "Eligibility Verification, Member Enrollment, and Customer Services." The list of services that require Prior Authorization, and the Authorization Request Form are located in the Provider Portal , and on the Provider page of the HPSJ website.

ADVANTAGES OF SUBMITTING AUTHORIZATIONS ONLINE

Providers can submit referrals online through the Portal or by fax at 209-942-6302. Online is the preferred mode of submission, with the following advantages for Providers:

- Immediate access to the status of the referral (not available for faxed requests)
- Direct communication with HPSJ staff via DRE regarding any aspect of the Authorization status

The following information is required for Authorization Requests:

- 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 and quantity requested

- Member diagnosis (ICD code and description)
- Signature of requesting Provider 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 the Provider Portal along with the Authorization request.)

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 the guidelines when all supporting clinical information that supports medical necessity is submitted along with the Authorization request.

EMERGENCY/URGENT CARE SERVICES

Emergency and Urgent Care Services are available at any time without 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 council 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.

Observation Stay

Certain HPSJ hospital service agreements contain a provision for an observation stay. An observation stay means a period of up to 24 hours when continuous monitoring, on an out-patient basis, is required to evaluate a Member's medical condition or determine the need for an inpatient admission.

An observation stay is only covered when ordered by a physician and meets medical necessity criteria. No Authorization is required for an observation stay lasting 0-24 hours.

The following is a list of conditions that may be appropriate for an observation stay.

Condition or Symptom	Purpose of Observation
Abdominal Pain	Rule out and manage pain
Chest Pain	Rule out and manage pain
Back Pain	Rule out and manage pain
Syncope	Rule out, stabilize and treat
Seizures	Rule out, stabilize and treat
Fever of unknown origin	Rule out, stabilize and treat
Asthma	Stabilize and treat
Bronchitis	Stabilize and treat
Bronchitis (pediatric only)	Stabilize and treat
Cellulitis	Culture, sensitivity test and plan of care
Concussion	Stabilize and observe
Croup (pediatric only)	Stabilize and treat
Dehydration	Stabilize and treat
Drug overdose	Stabilize, Manage and refer
Gastroenteritis	Stabilize and treat
Migraine headaches	Manage pain
Neurological deficit (pediatric only)	Rule out, stabilize and treat
Phlebitis	Rule out and stabilize
Pneumonia	Rule out and give first dose(s) of agent(s)
Renal colic/calculus	Stabilize and treat
General malaise and fatigue	Rule out, stabilize and treat

INPATIENT ADMISSIONS

All non-emergency (elective) admissions to Acute Care, Acute Rehabilitation, Long-Term Acute Care, and Long-Term Care facilities require Prior Authorization. Providers are also required to admit Members only to Hospitals contracted with HPSJ. Elective admissions to out-of-network facilities will require prior Authorization.

Long-Term Care

HPSJ covers long-term care services for members who need out-of-home placement in a long-term facility due to their medical condition.

Types of Long-Term Care Facilities

Medi-Cal covered long-term care services include placement in the following types of facilities:

- Nursing Facility Level A (NF-A) and Level B (NF-B)

Effective July 1, 2023, or as authorized by the Department of Health Care Services, HPSJ will cover the following additional types of facilities:

- Subacute Care Facilities – both adult and pediatric facilities
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- Intermediate Care Facilities for the Developmentally Disabled Habilitative (DD-DH)
- Intermediate Care Facilities for the Developmentally Disabled Nursing (DD-N)

HPSJ coordinates placement in a health care facility that provides the appropriate level of care based on Member's medical needs.

Criteria for Admission

The Medi-Cal long-term care benefit has specific criteria for admission to each type of long-term care facility based upon the member's diagnosis, physical limitations, and medical treatment needs. If a provider intends to refer an HPSJ member to a nursing facility, it is important to understand Medi-Cal's facility-specific criteria. Providers can use the following link to find the long-term care admissions criteria for each type of facility: www.medi-cal.ca.gov

Referring a Member to a Nursing Facility

Here are several important reminders for physicians who intend to refer an HPSJ member to a nursing facility:

1. To refer a member to a nursing home, the physician must order the admission and provide the following information:
    a. The members' medications, diet, activities, and medical treatments, such as wound care and labs.
    b. A current history and physical
    c. Diagnosis/diagnoses
    d. Indication of whether the physician will be following the member once admitted to the facility
2. In making the referral, the physician must identify the facility of admission. The member and/or the member's authorized representative may also seek the physician's counsel in determining an appropriate facility.
3. The admitting facility is responsible for obtaining authorization from HPSJ. The admitting facility will present medical justification for the level of care requested. If the authorization request is not approved or is modified, the member, physician, or facility has an option to appeal the determination.

Trauma Care

Certain HPSJ contracted hospital service agreements contain a provision for trauma care. The hospital must be a designated trauma facility to receive reimbursement for trauma care.

Trauma care is defined as inpatient or outpatient services provided during one uninterrupted admission or outpatient service initiated in a hospital emergency department of a Member who is treated directly by the hospital trauma-based care team. The Member's condition must meet the trauma triage protocol adopted by the American College of Surgeons committed on trauma or the hospital's specific emergency medical services criteria.

Trauma activation is defined as an on-site active participation of members of the trauma team including trauma surgeon, in the care of the Member from admission in the hospital emergency department, in accordance with the applicable triage guidelines and criteria and in response to the pre-arrival notification.

1. The initial evaluation of the Member must take place within 30 minutes of the Member arriving to the emergency department; this evaluation must take place within 8 hours of the traumatic event should the Member be transferred from another facility.

2. The hospital's contracted trauma reimbursement rate will not be paid if the initial evaluation of the Member does not take place within 30 minutes of the member arriving in the emergency department or within 8 hours of the traumatic event if the Member is transferred from another facility.

3. The activation of the trauma team must be in response to the notification of key hospital personnel by pre-hospital caregivers.

4. A Member who dies prior to arriving at the hospital cannot be charged the trauma team activation rate regardless of whether the pre-hospital caregiver notification was provided to the receiving hospital.

5. A Member who dies within 24 hours of arriving in the Emergency Department can be charged the outpatient trauma rate.

HPSJ requires the following documentation be submitted to the Utilization Management (UM) Department to allow trauma charges:

1. A trauma activation sheet completed at the time of the Emergency Department assessment and documentation submitted.

2. Documentation the nurse triage responded to the patient immediately upon arrival.

3. Documentation that the physician responded with a patient assessment within 15 minutes (Level1) and within 30 minutes (Level 2 and 3).

Trauma triage protocol per local county EMS agency includes the member meet at least one of the criteria listed below in order for a valid trauma activation and subsequent trauma charge:

1. Anatomic Criteria
    a. All penetrating injuries to head, neck, torso and extremities proximal to elbow and knee;
    b. Flail chest;
    c. Two or more proximal long-bone fractures;
    d. Crushed, degloved or mangled extremity;
    e. Amputation proximal to wrist and ankle;
    f. Pelvic fractures;
    g. Open or depressed skull fracture; or
    h. Paralysis
2. Physiologic Criteria
    a. Glasgow coma scale (GCS) of < 14;
    b. Systolic blood pressure (SBP) of < 90 mm HG; or
    c. Respiratory rate of < 10 or > 29 breaths per minute (< 20 in infant aged < 1 year)
3. Mechanism Criteria
    a. Falls
        i. Adults: fall > 20 feet (one story = 10 feet)
        ii. Children aged < 15 years: fall 10 feet or two to three times child's height;
    b. High-risk auto crash
        i. Intrusion: > 12 inches to the occupant site or > 18 inches to any site
        ii. Ejection (partial or complete) from automobile
        iii. Death in same passenger compartment
        iv. Vehicle telemetry data consistent with high-risk or injury;
        v. Auto versus pedestrian/bicyclist thrown, run over or with significant (> 20 mph) impact; or
        vi. Motorcycle crash > 20 mph

Administrative Day

Certain HPSJ contracted hospital service agreements contain a provision for administrative days. An administrative day means an authorized inpatient day for a Member who no longer meets medical necessity criteria for inpatient service at an acute care hospital, is unsafe for discharge and is pending placement in a nursing home or other subacute or post-acute care.

Authorization from HPSJ'S Utilization Management (UM) Department is required for an administrative day. The inpatient facility requesting the administrative day must submit daily documentation of the Member's condition, type of services received and documented reasonable five (5) attempts of placement efforts in a nursing home or other subacute or post-acute care. The hospital must continue daily placement attempts in a nursing home or subacute or post-acute care during the Member's administrative day stay.

SECTION 8: UTILIZATION MANAGEMENT

INPATIENT CONCURRENT REVIEW

To ensure quality and cost-effective inpatient care, Members must receive the appropriate level of care while they are in the inpatient setting. HPSJ's goal is a safe, efficient Member discharge transition to the most appropriate and least restrictive setting that meets the Member's needs. Upon admission to an inpatient facility, a Concurrent Review Registered Nurse (CCRN) reviews the facility clinical documentation to ensure the Member is receiving quality care at the appropriate intensity regardless whether the care is delivered in an acute, rehabilitation, skilled, or other inpatient setting. Clinical information should be submitted within 24 hours.

HPSJ's physicians and other licensed clinical staff apply national standards of care (*MCG*) 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.

HPSJ's CCRN leverages a team approach with facility staff to successfully coordinate medical care and plan for post-discharge needs. Updated clinical information which includes facility CM contact information should be submitted daily or as requested. The CCRN or Medical Director may need to contact the Attending Physician to address complex issues or problems that arise.

INITIAL HEALTH APPOINTMENTS

Within one hundred twenty (120) days of the date of Enrollment or change of PCP, PCPs must perform an Initial Health Appointment (IHA) for all Members. For members less than 18 months of age, IHA must happen within 120 calendar days of enrollment or within periodicity timelines established by the AAP Bright Futures for age 2 and younger, whichever is sooner.

An IHA must be provided in a way that is culturally and linguistically appropriate for the Member and must be documented in the Member's medical record.

An IHA must include ALL of the following:

- A history of the Member's physical and mental health.
- An identification of risks.
- Dental screening and oral health assessments 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.
- An assessment of need for preventive screens or services.
- Health education; and
- The diagnosis and plan for treatment of any diseases.

An IHA is not necessary if the PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months.

For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule. IHA must include age- appropriate childhood screenings including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and SUD.

For adults, PCPs should continue to provide all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the initial appointment, so long as members receive all required screenings in a timely manner consistent with USPSTF guidelines.

ADULT PREVENTIVE GUIDELINES

Screening Recommendations	21 to 39	40 to 49	50 to 65	65 and Older
Initial Health Visit	Within 120 days of enrollment			
History and Physical Exam	Every Year			
Blood pressure, Weight, and Height Check	With Every History and Physical			
Alcohol misuse screening and counseling	Recommended			
Drug misuse screening and counseling	Recommended			
Depression Screening	Recommended			
Obesity	Recommended			
Tobacco Use Screening	Recommended			
HIV Infections	Recommended			If at risk
Syphilis	If at risk			
Tuberculosis	If at risk			
BRCA Gene Screening	Talk to Doctor about risks (e.g. family history of breast or ovarian cancer)			
Chlamydia and Gonorrhea	Consult Doctor			
Intimate Partner Violence	Childbearing-aged women			
Cervical Cancer	Pap smear every 3 years, or every 5 years with HPV co-testing starting at age 30			
Abnormal Glucose/Diabetes		If overweight or obese		
Hepatitis C Screening	If at risk			
Colorectal Cancer		Recommended		
Breast Cancer		Biennial Screening		
Lunger Cancer Screening			If at risk	
Osteoporosis		If at risk		
Abdominal Aortic Aneurysm				If an "ever smoker"
Preventive Therapies				
Primary Prevention of Breast Cancer	If at risk			
Folic Acid Supplementation	If capable of conceiving			
Statins for Primary Prevention of CVD	If at risk			
Aspirin for Primary Prevention of CVD and Colorectal Cancer		If at risk		
Fall Prevention in Community-dwelling Older Adults			If at risk	
Immunizations				
Influenza	One dose annually			
Tetanus, diphtheria, pertussis (TDAP)	1 dose Tdap, the Td booster every 10 years			
Shingles (Zoster)			2 doses	
Pneumococcal Polysaccharide				1 dose
Pneumococcal Conjugate				1 dose
Meningococcal B	If at risk			
Meningococcal A, C, W, Y	If at risk			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			
HPV (Female)	2 or 3 doses depending on age at initial vaccination 19-26 yrs			
HPV (Male)	2 or 3 doses depending on age at initial vaccination 19 -21 yrs			
Chickenpox (Varicella)	2 doses (if born in 1980 or later)			
Hepatitis A	If at risk			
Hepatitis B	If at risk			
Hepatitis C (HCV)	If at risk			
Haemophilus influenza type b (Hib)	If at risk			
Counseling Recommendations				
Sexually Transmitted Infection	If at risk			
Diet/Activity for CVD	If at risk			
Skin Cancer	If at risk			

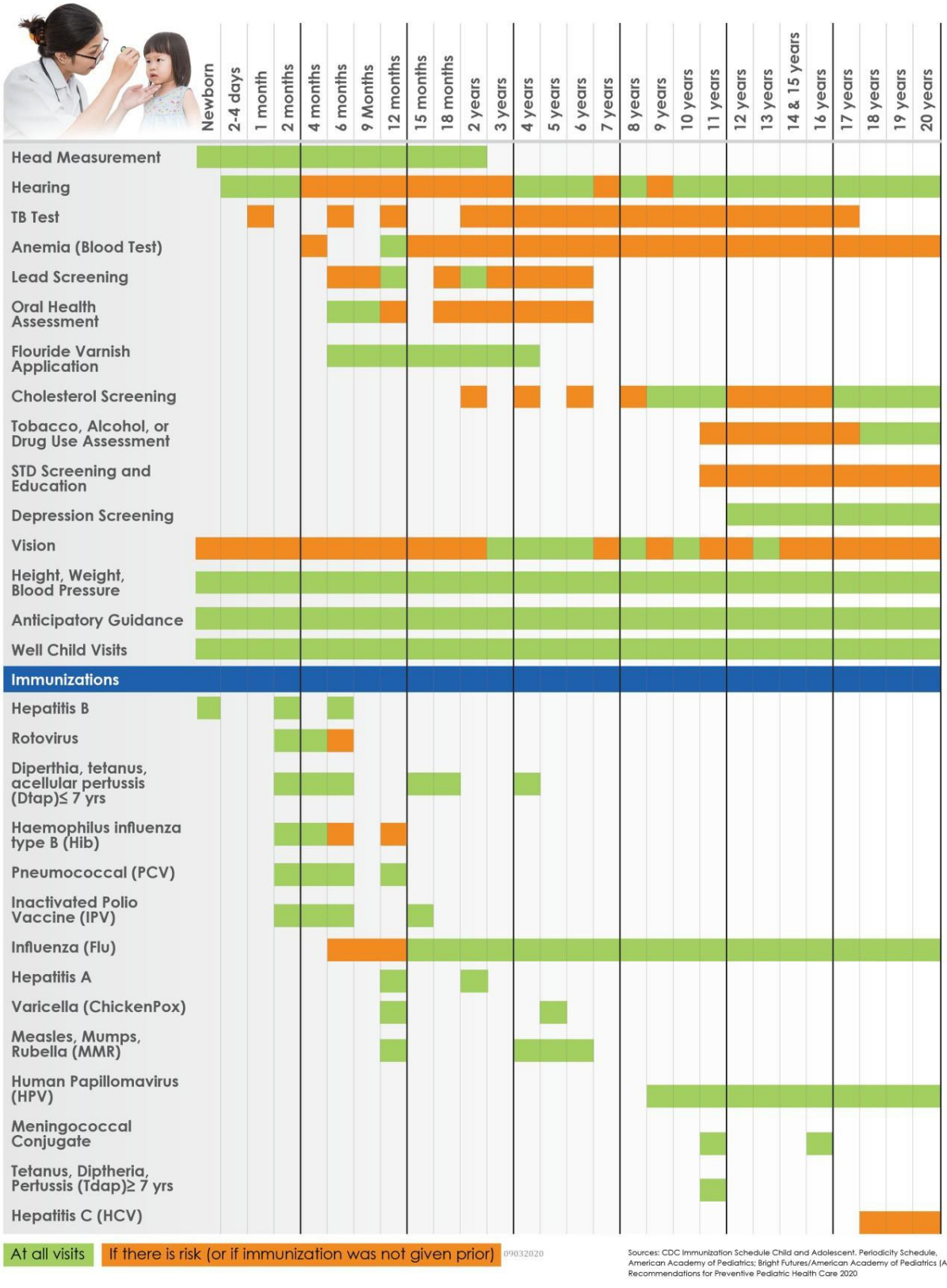
Recommended for Women Only | Recommended for Men Only | Recommended for all Adults

* CVD=Cardiovascular Disease

Sources: USPSTF Recommended Adult Preventive Health Care Schedule Grade A and B 2020, CDC Recommended Adult Immunizations 2020

09032020

PEDIATRIC PREVENTIVE GUIDELINES



BLOOD LEAD SCREENING OF YOUNG CHILDREN

All providers who perform Periodic Health Assessments (PHAs) on child members between the ages of six months to six years (i.e. 72 months) must comply with current federal and state laws, and industry guidelines for health care providers issued by the California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB), including any future updates to these guidelines.

Guidelines specific to lead screening are as follows:

1. Provide oral or written anticipatory guidance to the parent(s) or caregiver(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age. Anticipatory guidance must be provided to the parent or guardian at each PHA, starting at 6 months of age and continuing until 72 months of age.
2. Order or perform blood lead screening tests. Blood lead screening tests may be conducted using either the capillary (finger stick) or venous blood sampling methods; however, the venous method is preferred because it is more accurate and less prone to contamination. Testing must be performed on all child members in accordance with the following:
    a. At 12 months and at 24 months of age.
    b. When the network provider performing a PHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test performed at 12 months of age or thereafter.
    c. When the network provider performing a PHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test performed.
    d. At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
    e. If requested by the parent or caregiver.
    f. Laboratories and providers that perform a blood lead analysis drawn in California must electronically report all blood lead levels, along with the information specified in California Health and Safety Code, Section 124130, to the EBLR System.
3. Follow up must be performed for all positive screening results. While the minimum requirements for appropriate follow-up activities, including referral, case management and reporting, are set forth in the CLPPB guidelines, a provider may determine additional services that fall within the EPSDT benefit are medically necessary. HPSJ will ensure that members under the age of 21 receive all medically necessary care as required under EPSDT.
4. Reporting timeframe for all blood lead results:
    a. Greater than or equal to 10 ug/dl must be reported within 3 working days of analysis.
    b. Less than 10 ug/dl must be reported within 30 calendar days of analysis.

Reporting of the blood lead test results to the State go into a system called The Response and Surveillance System for Childhood Lead Exposures (RASSCLE).

Providers may also report directly to San Joaquin County Public Health Services Childhood Lead Poising Prevention Program (CLPPP), by faxing the results to **(209) 953-3632**. Once received via fax and reviewed they will be entered into RASSCLE if they are not, they will send them to the State to be uploaded into RASSCLE.

For more information
Blood Lead Reporting Requirements Website:
https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/report_results.aspx
Blood Lead reporting inquiries: EBLRSupport@cdph.ca.gov or complete the EBLR Contact Form

5. Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

6. Network providers are not required to perform a blood lead screening test but should clearly document in patient medical record if either of the following applies:

    a. In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.

    b. If a parent, caregiver, or other person with legal authority chooses to withhold testing, the provider must obtain and retain a signed statement of voluntary refusal along with the reason for the refusal to consent to the screening. This evidence shall be retained to ensure compliance with Blood Lead Screening requirements.

    c. Follow the current CLPPB issued guidelines when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up care. Including additional confirmatory venous testing, referrals, case management and reporting as set forth in the CLPPB guidelines. Additionally, network providers may determine additional services that fall within the Early and Periodic Screening, Diagnostic and Testing (EPSDT) benefit are medically necessary.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)- 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
- Appropriate laboratory tests (including lead toxicity screening)

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.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and Preventative Care

HPSJ and its contracted practitioners and providers must comply with state and federal laws and regulations regarding the provision of Medi-Cal services including Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The EPSDT benefit is set forth in the Social Security Act (SSA) Section 1905(r) and Title 42 of the United States Code (USC) Section 1396d. 1, 2. The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program.

According to guidance from the Centers for Medicare and Medicaid Services (CMS), titled EPSDT — A Guide for States,

"The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting."

"California Welfare and Institutions Code, section 14059.5, subd. (b), defines medically necessary services for individuals under 21 years of age as those services that meet the standards set forth in Section 1396d(r)(5) of Title 42 of The United States Code. Accordingly, a service is considered "medically necessary" or a "medical necessity" if it corrects or ameliorates defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan".

HPSJ adopts Preventative Screening Guidelines recommended by The American Academy of Pediatrics, Bright Futures Guidelines, Guidelines for the Pediatric Prevention Care and American Academy of Family Physicians Adult Preventative Guidelines.

Linked and carved out services must be coordinated for the following services when a need is identified:

Behavioral Health

Prior authorization is not required for referral to an in-network BH practitioner. If out of network services are needed for continuity of care or other medically necessary reasons please submit a prior authorization request. Physician and other medical practitioner offices can refer members directly to in-network BH practitioners listed in HPSJ's provider directory, members can call for appointments directly (they can self- refer) , call HPSJ's customer service at 1.888.936.PLAN(7526) or assistance or call our MBHO Carelon at 1.888.581.7526 or questions and assistance.

Behavioral Health Treatment or Applied Behavior Therapy for members with Autism.

PCP Referral Options:

1. For members under age 21 that need BHT services for autism: Fax completed PCP Referral Form, Progress Note with MD order for BHT/ABA services with documentation supporting that BHT is medically necessary to (877) 321-1776 or send via secure email to ASGCare.Managers@carelon.com. Include member consent to allow confirmation of referral process.
2. Call Carelon Service Center at (855) 834-5654 during normal business hours (M-F 8:30 am-5 pm) for any questions or guidance regarding the referral process. Press 2 to bypass the phone tree. Say, "I am calling from a PCP office and requesting a referral for BHT/ABA services for my patient. Also applies to community providers.

Carelon's Next Steps:

- BHT Services Care Coordinator contacts member to assist securing resources for services
- Carelon will contact the PCP to confirm completion of referral process

carelon

Health Plan of San Joaquin

Date: _____ **Referral By:** _____ **Referral Phone #:** _____

Member Name: _____ **Member ID:** _____

Gender: ☐Male ☐Female **DOB:** _____ **Age:** _____

Address: _____ **Member Phone:** _____

Best time of day to reach member: _____ **Language/Culture:** _____

Caregiver/Family/Support: _____ **Contact Phone:** _____

Current Symptoms:

☐Depressed mood
☐Anxiety/Panic attacks
☐Risk of self-harm or harming others
☐High impulsivity/Aggression
☐History of physical or emotional trauma
☐Hyperactivity
☐Obsessions/Compulsions
☐Psychosis (hallucinations, delusions, etc.)
☐Somatic complaints
☐Substance abuse (active)
☐Substance abuse history (within the last 12mos)
☐Palliative care

Member Behavioral Health Diagnosis: _____

Areas of concern (include information such as psych hospitalization, medication, level of functioning):

_____

_____

_____

_____

Medical Conditions: _____

Medications:

_____

_____

_____

Medical and Behavioral Health Providers:

Name	Specialty	Phone Number

Motivation for Services (check all that apply):

☐Member would like support
☐Member has been informed that a behavioral health referral has been made
☐Member has been admitted to Palliative Care Program

Fax completed referrals to: 855-371-3946

DEVELOPMENTAL DISABILITIES SERVICES (DDS)

A developmental disability is a disability which originates before an individual reaches twenty-one

(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 or Specialists must screen and identify individuals with significant developmental delay or those at risk for developmental disability and make the appropriate referral to Valley Mountain Regional Center and for cognitive delays and behavioral health concerns to Carelon Behavioral Health for evaluation & referral for services. 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.
- For members that need care coordination and case management or social needs please refer them to HPSJ's case management team at (209) 942-6352 or HPSJ's social work team at (209) 942-6395.

VALLEY MOUNTAIN REGIONAL CENTER

The Valley Mountain Regional Center (VMRC) is a nonprofit that has a contract with Department of Developmental Services to provide or coordinate services and support for individuals with developmental disabilities who reside in San Joaquin and Stanislaus Counties

To be eligible for VMRC services the person must have a disability that begins before the individual's 18th birthday that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, epilepsy, autism, and other conditions as defined in Section 4512 of the California Welfare and Institutions Code.

Services offered by VMRC include:

- Early intervention services for at risk infants and families
- Genetic counseling
- Family support
- Case management
- Respite care
- Adult day program services

Providers can refer members to VMRC by contacting their office:

San Joaquin Main Office:
702 N Aurora St. PO Box 692290
Stockton, CA 95269-2290
Phone: 209-473-0951

Stanislaus:
1820 Blue Gum Ave
Modesto, CA 95358
Phone: 209-529-2626

Providers who want more information on VMRC, can visit their website at www.vmrc.net.

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. 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 CCS eligible services.

The CCS program requires authorization for health care services related to a child's CCS-eligible medical condition. Providers must request CCS services to CCS 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 Members 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 health plan remains responsible for all other required services including preventative services for everything except the CCS eligible services.

Members must be diagnosed with a CCS qualifying condition. CCS eligible conditions include but are not limited to:

- AIDS
- Cancer
- Cataracts
- Cerebral palsy
- Chronic kidney disease
- Cleft lip/palate
- Congenital heart disease
- Diabetes
- Endocrine, Nutritional, and Metabolic Diseases and Immune Disease
- Hearing loss
- Hemophilia
- Intestinal disease
- Infectious Diseases
- Liver disease
- Medical Therapy Program
- Mental Disorders
- Muscular Dystrophy
- Neoplasms
- Prematurity
- Rheumatoid arthritis
- Severe burns
- Severe crooked teeth
- Severe head, brain or spinal cord injuries
- Sickle cell anemia
- Spina bifida
- Thyroid conditions
- Tumors

For a complete list of CCS eligible conditions refer to the CCS website. Providers can refer members to CCS by contacting the CCS county office at:

San Joaquin County California Children's Services
2233 Grand Canal Blvd Suite 214
Stockton, CA 95207
209-468-3900

Stanislaus County California Children's Services
917 Oakdale Road
Modesto, CA 95355
209-558-7515

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Children with Special Health Care Needs (CSHCN) are defined by the Department of Health Care Services (DHCS) 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 Specialists are responsible for identifying Members with potentially eligible conditions and subsequently referring those Members to appropriate programs for genetically handicapped persons. Members that require evaluation and services for developmental delay should be referred to the Valley Mountain Regional Center (VMRC) which is the primary referral source for HPSJ's Service Area.

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

AIDS Medi-Cal Waiver Program

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home- and community-based services as an alternative to nursing facility care or hospitalization.

The Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization. Case management is participant centered and provided using a team-based approach by a registered nurse and social work case manager. Case managers work with the participant, their primary care provider, family, caregivers, and other service providers to determine and deliver needed services to participants who choose to live in a home setting rather than an institution.

The goals of the MCWP are to:

- Assist participants with disease management, preventing HIV transmission, stabilizing overall health, improving quality of life, and avoiding costly institutional care.
- Increase coordination among service providers and eliminate duplication of services.
- Transition participants to more appropriate programs as their medical and psychosocial status improves, thus freeing MCWP resources for those in most need; and • Enhance utilization of the program by underserved populations.

Clients eligible for the program must be Medi-Cal recipients: whose health status qualifies them for nursing facility care or hospitalization, in an "Aid Code" with full benefits and not enrolled in

the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disabilities related to HIV disease or treatment; adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service providers.

For further information refer to the Office of AIDS.

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 prior authorization approval by HPSJUM Department.

HPSJ uses *Milliman Care Guidelines* to determine the medical necessity for the admission, 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 for post hospitalization admission. 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 after the first 24 hours of admission. Post stabilization admissions for out of network hospitals will be paid at a DRG rate. Call the UM line for authorization of services 209- 461-2205 prior to admitting to an inpatient stay.

Outpatient and Ancillary Referrals

Providers should consult the Provider Portal 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.

SECTION 8: UTILIZATION MANAGEMENT

Prior Authorization

Health Plan of San Joaquin (HPSJ) requires all covered services for physical and behavioral health conditions that require authorization, be submitted to the HPSJ utilization management (UM) department for review for medical necessity.

HPSJ's physicians and other licensed clinical staff apply national standards of care MCG to determine the medical necessity for outpatient services. If the requested service is not addressed in the MCG guidelines the Medi-Cal criteria in the Medi-Cal provider Manual is utilized, If there are no applicable guidelines in both resources, the reviewer will consult HPSJ's internal policies, followed by peer reviewed, published literature to determine the medical necessity for the requested service. If medical necessity criteria is not met or if sufficient clinical information is not provided to determine the medical necessity for the requested outpatient service, it will be denied by the Medical Director.