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SECTION 8: UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT PROGRAM OVERVIEW

Health Plan Advantage D-SNP has Utilization Management (UM) policies and procedures that support the provision of quality and equitable health care services for Enrollees enrolled in D-SNP. The goal of UM is to provide Enrollees with the right care, in the right place, within the most appropriate timeframe across both Medicare Advantage and Medi-Cal benefits. The UM program staff provide guidance to Providers to support care in all 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 Health Plan Advantage D-SNP'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 considering the Enrollees needs.

UM processes are designed to be unified so the Enrollees experience a single, coordinated approach to requests, determinations, notices, and appeals across Medicare and Medi-Cal.

COUNSELING ENROLLEES ON TREATMENT OPTIONS

Every Provider has the responsibility of counseling Enrollees on the course and options in medical treatment, regardless of whether the service is a covered benefit. The Care Management Department will assist and provide care coordination, case management, and disease management services for Enrollees at risk for substantial ongoing care. The Care Management Department will also assist in establishing whether the Enrollee is eligible for other medical programs available through federal or state agencies, as well as local community resources.

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 to ensure services are medically necessary and consistent with evidence-based, nationally recognized clinical guidelines.

Health Plan Advantage D-SNP's physicians and other licensed clinical staff apply Medicare coverage rules first, including National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and Medicare statutes and manuals. If no Medicare criteria apply, nationally recognized evidence-based guidelines such as MCG may be used as a secondary reference. If the requested service is not addressed by Medicare or MCG, Medi-Cal State Plan criteria may be applied. If no applicable criteria exist, reviewers will consult Health Plan Advantage D-SNP's internal policies and peer-reviewed, published literature to support the decision.

If medical necessity criteria are not met, or if sufficient clinical information is not provided to make a determination, the request will be denied by the Medical Director.

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At any time, a Provider may request a copy of criteria used to make medical necessity decisions during the utilization review process by calling Health Plan Advantage D-SNP at 1-888-361-7526 (TTY: 711). 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 deny a request for services based on medical necessity.

INPATIENT CARE

Health Plan Advantage D-SNP reviews admissions, length of stay, and treatment options in accordance with Medicare coverage rules, including the Medicare Managed Care Manual, National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). If no applicable Medicare criteria exist, the plan uses nationally recognized evidence-based guidelines such as MCG. If the service is not a Medicare-covered benefit but is covered under Medi-Cal, Medi-Cal State Plan criteria are applied.

It is imperative that the facility team and Health Plan Advantage D-SNP work together for the clinical benefit of the Enrollee, discharge planning and transitions of care coordination, and clarity in claims processing.

At any time, a Provider may request a copy of criteria used to make medical necessity decisions during the utilization review process by calling Health Plan Advantage D-SNP at **1-888-361-7526 (TTY:711)**. 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 deny a request for services based on medical necessity.

HOSPITAL CARE

Planned (elective) admissions

The admitting Provider must obtain authorization from Health Plan Advantage D-SNP prior to the Enrollee's admission. Prior authorization requests are processed within seven calendar days of receipt of all necessary information, or within 72 hours for expedited requests. No extensions are permitted.

Procedures on Medicare's Inpatient-Only (IPO) list are applied only when performed in the inpatient hospital setting. These services will not be covered if performed in an outpatient setting and must be submitted as inpatient authorization requests.

Requests may be submitted online through the Provider Portal Doctor's Referral Express (DRE) at www.hpsj-mvhp.org/Providers, or by fax at 209-762-4702.

Observation

If an Enrollee is seen in the emergency room (ER) and held for observation (not admitted), observation services are reimbursed per the contracted rate for up to 24 hours. Observation services

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beyond 24 hours require notification and clinical documentation to support medical necessity, which should be submitted online through the DRE at www.hpsj-mvhp.org/Providers, or by fax at 1-209-762-4702. See section 8, page 6 of this manual for additional information.

Emergency and Post-Stabilization Admissions

If an Enrollee is seen in the ER and admitted for stabilization and further treatment, no authorization is required for services necessary to stabilize the Enrollee. Once the Enrollee has been stabilized, the Provider must notify Health Plan Advantage D-SNP within one business day and submit clinical documentation to support medical necessity of ongoing inpatient services. This information should be submitted online through the DRE at www.hpsj-mvhp.org/Providers, or by fax at 1-209-762-4702.

Providers must notify Health Plan Advantage D-SNP once the treating physician determines the member is stabilized to request a post-stabilization authorization from Health Plan Advantage D-SNP. Health Plan Advantage D-SNP is responsible for responding to the request for post-stabilization care within 30 minutes of the request, or the care is deemed approved. Health Plan Advantage D-SNP provides 24-hour access for authorization or transfer coordination and complies with Medicare regulations and California Health & Safety Code §1262.8. Enrollees may not be balance-billed for post-stabilization services.

Continued Stay (Concurrent) Review

If an Enrollee 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 DRE at www.hpsj-mvhp.org/Providers, or by fax at 1-209-762-4702.

Requests are processed within 72 hours of receipt. All continued stay reviews are conducted in accordance with Medicare coverage rules.

Retrospective Authorizations

Health Plan Advantage D-SNP does not require retrospective authorization for Medicare-covered services. Coverage determinations are made prospectively (prior authorization) or concurrently (continued stay review). Services rendered without prior authorization, when required, will be reviewed through the claims process.

UTILIZATION MANAGEMENT STAFF AVAILABILITY

Providers are encouraged to contact Health Plan Advantage D-SNP's UM Staff and/or Medical Directors to discuss referrals, case management services for specific Enrollees, or other areas of concern.

UM Staff Availability during Normal Business Hours

Health Plan Advantage D-SNP's UM staff are available Monday through Friday from 8:00 am to

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5:00 pm pacific time, to respond to utilization management inquiries from Enrollees and Providers. UM staff can be reached at 1-888-361-7526 (TTY:711). Providers may also use the Provider portal to connect with the Intake Processor of the Day (IPOD) for assistance with authorizations. A Medical Director may be reached for UM issues at 1-209-942-6431.

UM Staff Availability After Hours

In accordance with CMS requirements, Health Plan Advantage D-SNP accepts prior authorization requests 24 hours a day, seven days a week, including holidays.

Providers may call 1-888-361-7526 (TTY: 711) after hours to submit any request, including urgent admissions, post-stabilization services or other coverage determinations. All requests received outside business hours are logged and time-stamped at the time submitted and processed within the applicable CMS timeframes.

Providers who need assistance with routine matters after normal business hours may also leave a secure voicemail at 1-888-361-7526 (TTY:711). Voicemail messages are retrieved each business day at 8:00 a.m. by a customer services representative, who responds to the call or routes the message to the appropriate UM staff. Responses are returned no later than the next business day.

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

Health Plan Advantage D-SNP maintains a comprehensive network of Providers to ensure 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 Health Plan Advantage D-SNP. These Providers also meet the standards for timely and geographic access for Enrollees. If Providers are experiencing difficulty in locating an in-network Provider that meet the Enrollees medical needs, they should contact the UM Department at 1-209-942-6431.

In some cases, Health Plan Advantage D-SNP may have exclusive contracts with specialty Providers. In these instances, referrals must be directed to these Providers. Currently all laboratory, and some vision and durable medical equipment services, are contracted through specific vendors. For more information on referrals to Providers, please contact the UM Department at 1-209-942-6431.

If covered services are needed from an out-of-network Provider, please contact the UM Department at 1-209-942-6431 to obtain approval for the referral. Health Plan Advantage D-SNP's Contracting Department will contact Providers that may be available to meet the clinical needs of the Enrollee.

CONTINUITY OF CARE

Health Plan Advantage D-SNP provides continuity of care for Enrollees when their Provider is no longer part of the network or when the Enrollee is transitioning into Health Plan Advantage D-SNP coverage. Continuity of care is provided automatically when criteria are met, but may also be initiated by the Enrollee or Provider.

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- **Primary Care Provider (PCP) and Specialist Providers:** Enrollees may continue to see a non-contracted PCP or specialist for up to 12 months when the Enrollee has an existing relationship with the Provider, the Provider agrees to work with Health Plan Advantage D-SNP at the applicable reimbursement rate and the Provider has no substantial quality-of-care concerns.
- **All Other Providers/Services:** For other providers and services, continuity of care is honored for up to 90 days if the Enrollee is actively receiving treatment. This includes services such as dialysis, home health, outpatient therapies, or other non-specialist care.

At the end of the continuity period, Enrollees must transition to in-network Providers to continue receiving covered services. Health Plan Advantage D-SNP will assist in coordinating this transition to ensure there is no disruption in care. If Health Plan Advantage D-SNP does not have an in-network Provider available to deliver the medically necessary service, the Enrollee may continue care with the non-contracted Provider for as long as medically necessary, at no additional cost to the Enrollee.

Although Health Plan Advantage D-SNP is responsible for initiating continuity of care when criteria are met, Providers may also request continuity of care on behalf of the Enrollee. If a non-contracted Provider is providing services to an Enrollee, he/she may initiate a request for continuity of care by submitting a Medical Authorization Form available on Health Plan Advantage D-SNP's website at www.hpsj-mvhp.org. or by contacting Health Plan Advantage D-SNP's Customer Service Department at **1-888-361-7526(TTY: 711)**.

OBTAINING A SECOND OPINION

Health Plan Advantage D-SNP honors the Enrollee's right to obtain a second opinion from another Provider when indicated. To coordinate this, the Enrollee 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 requesting Provider in writing of the result of the authorization request and assist the Enrollee with making arrangements for the second opinion upon request.

Health Plan Advantage D-SNP will allow a second opinion to Enrollees by an appropriately qualified healthcare professional, if requested by an Enrollee or a participating Provider who is treating the Enrollee. An authorization is not needed for a second opinion with an in-network Provider. If the Provider is out of network, authorization is needed. Health Plan Advantage D-SNP will also arrange transportation if needed for the second opinion.

COVERED SERVICES THAT DO NOT NEED PRIOR AUTHORIZATION

Health Plan Advantage D-SNP permits an Enrollee to obtain some covered services without prior authorization. A complete list of these covered services can be found on the Provider portal and should be regularly reviewed for changes.

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However, the following covered services never require prior authorization. Enrollees may choose an in-network Provider or an out-of-network Provider for:

- Emergency Services
- Certain preventative services in-network (Access the Provider portal for more information)
- Basic prenatal care in-network
- HIV testing
- Family planning
- Treatment and diagnosis of sexually transmitted diseases (STDs)
- Well women health service in-network
- Initial mental health and SUD assessments

ONGOING SPECIALTY CARE AUTHORIZATIONS

Enrollees with serious or ongoing health conditions may require extended access to a specialist. Health Plan Advantage D-SNP will authorize ongoing specialty care when medically necessary:

- **In-Network:** Enrollees will be directed to contracted specialists when available.
- **Out-of-Network:** If there is no qualified in-network specialist available, Health Plan Advantage D-SNP will authorize specialty care with an out-of-network Provider at no additional cost to the Enrollee.
- **Duration:** Authorizations for ongoing specialty care may be issued for up to 12 months, or longer if medically necessary, based on the Enrollee's treatment plan.

Ongoing specialty care authorizations are appropriate for conditions that require long-term specialized care. Examples include cancer, HIV/AIDS, lupus, renal failure, cystic fibrosis, severe neurological conditions, transplant candidacy, acute leukemia, and high-risk pregnancy. Authorizations may also be issued for other life-threatening, degenerative, or disabling conditions when medically necessary.

Affirmative Statement on Incentives

Health Plan Advantage D-SNP's UM decision making is based solely on appropriateness of care, service, and existence of coverage. Health Plan Advantage D-SNP does not specifically provide incentives for the individual provider or entity to deny, limit, or discontinue medically necessary services to any member/enrollee.

SUBMITTING REQUESTS FOR AUTHORIZATIONS

Providers must verify an Enrollee's eligibility before submitting a prior authorization for covered services. Eligibility may be verified through the Provider portal. Alternate methods to verify eligibility are detailed in this Manual under "Eligibility Verification, Enrollee 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 Health Plan Advantage D-SNP's website.

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ADVANTAGES OF SUBMITTING AUTHORIZATIONS ONLINE

Providers can submit prior authorizations online through the Provider portal or by fax at 1-209-762-4774. Online is the preferred mode of submission with the following advantages for Providers:

- Immediate access to the status of the prior authorization request (not available for faxed requests)
- Direct communication with Health Plan Advantage D-SNP staff via the Provider portal regarding any aspect of the authorization status

The following information is required for authorization requests:

- Enrollee’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
- Enrollee 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

⁵The turnaround time for a prior authorization depends on the type of request:

- **Expedited Request:** Within 72 hours of receipt of the request.
- **Standard Request:** Within seven calendar days of receipt of the request.
- **Standard Part B Drug Request:** Within 72 hours of receipt of the request.
- **Expedited Part B Drug Request:** Within 24 hours of receipt of the request.

Authorization determinations are made in accordance with applicable Medicare guidelines. No extensions are permitted.

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DISMISSALS

In certain situations, Health Plan Advantage D-SNP may dismiss a request for an initial determination. A dismissal means the request cannot proceed as submitted. A dismissal notice will be issued to the Enrollee and Provider explaining the reason and outlining rights to request review of the dismissal.

A request may be dismissed when:

- The individual or entity submitting the request is not permitted under Medicare rules.
- The request does not meet the requirements to be considered valid (e.g., insufficient information to identify the Enrollee).
- The Enrollee passes away while the request is pending and no party with a financial interest wishes to continue.
- The request is withdrawn by the Enrollee or their representative.

Dismissals are binding unless modified, reversed, or vacated. A party may request review of a dismissal within 65 days of the dismissal notice. Health Plan Advantage D-SNP may also vacate a dismissal for good cause if evidence shows the dismissal was issued in error.

EMERGENCY/URGENT CARE SERVICES

Emergency and urgent care services are available at any time, without prior authorization. Health Plan Advantage D-SNP covers emergency services, including screening and stabilization, wherever the Enrollee presents for care. Enrollees cannot be billed, charged, or held financially liable for emergency or urgent care services.

PCPs may help Enrollees understand appropriate use of the ER for non-emergency conditions and encourage use of contracted urgent care centers when clinically appropriate. Urgent care centers throughout the service area offer extended hours and shorter waiting times compared to emergency departments.

Observation Stay

Observation services are covered as outpatient hospital services when ordered by a physician and when medical necessity criteria are met. No authorization is required for an observation stay of up to 24 hours. If an observation extends beyond 24 hours, clinical documentation must be submitted for continued review.

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 Enrollees only to hospitals contracted with Health Plan Advantage D-SNP. Elective admissions to out-of-network facilities will also require prior Authorization,

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Long-Term Care

Health Plan Advantage D-SNP covers long-term care services for Enrollees who require out-of-home placement due to their medical condition.

- **Medicare:** Skilled Nursing Facility (SNF) care is covered under Medicare Part A when criteria are met, including a qualifying inpatient stay and skilled nursing needs. Coverage is generally limited to 100 days per benefit period.
- **Medi-Cal:** When Medicare coverage ends or criteria are not met, Medi-Cal may cover long-term custodial care or placement in specialized facilities. This includes nursing facilities, subacute care, and intermediate care facilities for the developmentally disabled. Health Plan Advantage D-SNP coordinates placement at the appropriate level of care based on the Enrollee's medical needs.

Criteria for Admission

Admission criteria are determined first using Medicare coverage rules. SNF admissions must meet Medicare Part A requirements, including medical necessity, qualifying inpatient stay, and need for skilled services.

When Medicare coverage does not apply or has been exhausted, Medi-Cal criteria are used to determine admission for long-term custodial or specialized facility care. Providers may access Medi-Cal facility-specific criteria at www.medi-cal.ca.gov.

Referring an Enrollee to a Nursing Facility

Here are several important reminders for physicians who intend to refer a Health Plan Advantage D-SNP Enrollee to a nursing facility:

1. To refer Enrollees to a nursing home, the physician must order the admission and provide the following information:
 - a. The Enrollees' medications, diet, activities, and medical treatments, such as wound care and labs.
 - b. Current history and physical
 - c. Diagnosis/diagnoses
 - d. Indication of whether the physician will be following the Enrollee once admitted to the facility
2. In making prior authorization requests, the physician must identify the facility of admission. The Enrollee and/or the Enrollee'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 Health Plan Advantage D-SNP. The admitting facility will present medical justification for the level of care requested. If the authorization request is not approved, the Enrollee, physician, or facility has an option to appeal the determination.

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Trauma Care

Health Plan Advantage D-SNP covers medically necessary trauma care when an Enrollee is treated at a designated trauma facility. Trauma care includes inpatient or outpatient services provided during one uninterrupted admission or emergency department episode of care.

- Trauma care is covered without prior authorization, consistent with the prudent layperson standard under Medicare.
- Enrollees cannot be billed or held financially liable for trauma services.
- Designated trauma facilities are required to follow trauma triage protocols established by the American College of Surgeons or the local county Emergency Medical Services (EMS) agency as part of their trauma center designation.
- Health Plan Advantage D-SNP reimburses contracted trauma facilities in accordance with their trauma care agreements.

INPATIENT CONCURRENT REVIEW

To ensure quality and cost-effective inpatient care, Enrollees must receive the appropriate level of care while in the inpatient setting. Health Plan Advantage D-SNP's goal is a safe, efficient Enrollee discharge transition to the most appropriate and least restrictive setting that meets the Enrollee's needs.

Upon admission, a Concurrent Review Registered Nurse (CCRN) reviews the facility clinical documentation to ensure the Enrollee is receiving quality care at the appropriate intensity regardless of whether the care is delivered in an acute, rehabilitation, skilled, or other inpatient setting. Clinical information should be submitted within 24 hours.

Health Plan Advantage D-SNP's physicians and other licensed clinical staff initially apply Medicare coverage rules including NCDs, LCDs and Medicare manuals to determine the medical necessity of the inpatient stay and the appropriate level of care (e.g., acute medical-surgical, telemetry, intermediate, or intensive care). If no Medicare criteria apply, nationally recognized evidence-based guidelines such as MCG may be used as a secondary reference. If the requested service is not addressed by Medicare or MCG, Medi-Cal criteria may be applied. If no applicable criteria exist, reviewers will consult Health Plan Advantage D-SNP's internal policies and peer-reviewed, published literature to support the decision.

If medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the inpatient stay or the level of care requested, the case will be reviewed by a Medical Director. When a request is denied, the facility and Provider are notified of the reason and the Enrollee's appeal rights.

Health Plan Advantage D-SNP'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 Care Manager (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.

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REOPENINGS

Health Plan Advantage D-SNP may reopen or revise a coverage or authorization decision that has already been issued. Reopenings are not new requests or appeals, but a correction of the prior decision.

A reopening may occur:

- To correct a clerical error (such as a typographical error in dates or codes).
- When new or missing information is received that affects the outcome.
- When good cause exists, such as evidence showing the original decision was incorrect.

Requests for reopening must generally be made within six months of the original decision. If a reopening is granted, the timeframe for the new determination begins on the date Health Plan Advantage D-SNP decides to reopen the case.

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ADULT PREVENTIVE GUIDELINES



When it comes to patient care, HPSJ/MVHP is on your team. We understand that preventive health care is about improving quality of life. This quick reference guide is here to help you reach those goals with your patients.



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 and Anxiety Screening	Recommended			
Obesity	Recommended			
Tobacco Use Screening	Recommended			
HIV Infections	Recommended			If at risk
Syphilis	If at risk			
Tuberculosis	Screen all and test at risk			
BRCA Gene Screening	Talk to Doctor about risks (e.g. family history of breast or ovarian cancer)			
Chlamydia and Gonorrhea	Screening in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection			
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	Recommended			
Hepatitis C Screening	If at risk			
Colorectal Cancer	Recommended			
Breast Cancer	Biennial Screening			
Lung 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 and COVID-19	One dose annually			
Tetanus, diphtheria, pertussis (TDAP)	1 dose Tdap, the Td booster every 10 years			
Shingles (Zoster)	2 doses			
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 influenzae type b (Hib)	If at risk			
RSV for pregnant people	If at risk			
Counseling Recommendations				
Sexually Transmitted Infection	If at risk			
Diet/Activity for CVD*	If at risk			
Skin Cancer	If at risk			
Weight	BMI 18.5 - 29.9 kg/m ²			
Recommended for Women Only	Recommended for Men Only		Recommended for all Adults	

* CVD=Cardiovascular Disease

For full guidelines visit www.uspreventiveservicestaskforce.org

Sources: USPSTF Recommended Adult Preventive Health Care Schedule Grade A and B 2024, CDC Recommended Adult Immunizations 2024

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Behavioral Health Care Services

Prior authorization is not required for referral to an in-network mental health practitioner for most outpatient services. If out-of-network services are needed for continuity of care, Health Plan Advantage D-SNP will honor access in accordance with continuity of care requirements. For other medically necessary out-of-network services, a prior authorization request must be submitted. (see Forms & Documents for HPSJ/MVHP Providers).

For transcranial magnetic stimulation (TMS) and higher levels of care (such as intensive outpatient, partial hospitalization program, inpatient psychiatric hospitalization, and/or residential treatment), a prior authorization with supporting documentation is needed in order to be reviewed for medical necessity and referred to an in-network provider. (see Forms & Documents for HPSJ/MVHP Providers).

Physicians and other medical practitioner offices can refer Enrollees directly to in-network mental health practitioners listed in Health Plan Advantage D-SNP's Provider directory, Enrollees can call for appointments directly (they can self-refer), or call Health Plan Advantage D-SNP's Behavioral Health Customer Service Department at **1-888-361--7526 (TTY: 711)** for questions and assistance.

DEVELOPMENTAL DISABILITY SERVICES (DDS) AND DISABLED ADULT CHILDREN (DAC)

Some Enrollees with developmental disabilities may qualify for Medicare coverage as Disabled Adult Children (DACs). A DAC is an individual aged 18 or older with a qualifying disability that began before age 22, who receives benefits based on a parent's Social Security record. Medicare eligibility generally begins after 24 months of Social Security Disability Insurance (SSDI) benefits, or sooner for individuals with Amyotrophic Lateral Sclerosis (ALS). Providers should be aware that many adult Enrollees with developmental disabilities may have Medicare through this pathway, even if they have never worked.

When Medicare does not cover a needed service, Medi-Cal benefits apply, including services available through California's Developmental Disability Services (DDS) and Regional Centers (RCs).

A developmental disability is a disability which originates before an individual reaches 21 years old, continues or can be expected to continue indefinitely, and constitutes a substantial disability for that individual. Conditions may include developmental delay, cerebral palsy, epilepsy, autism, or other disabling conditions, but exclude conditions that are solely physical in nature.

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REGIONAL CENTERS

Regional Centers (RC) are nonprofit agencies that have a contract with the Department of Developmental Services that provide or coordinate services for individuals with developmental disabilities. In the service area (Alpine, El Dorado, San Joaquin, and Stanislaus Counties), Regional Centers remain the lead entities for certain developmental services.

To be eligible for RC services, Enrollees must have a qualifying disability that begins before age 18, 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 RCs include:

- Diagnosis and assessment of eligibility
- Access, coordinate and monitor services and supports
- Early Start Therapeutic services
- Adult day centers/program services
- Behavioral Management Services
- Client/Parent Support/Behavior Intervention Training
- Crisis Intervention Facility/Bed
- Crisis Team – Evaluation and Behavioral Intervention
- Day Care Services
- Durable Medical Equipment
- Employment Programs
- Family Home Agency
- Foster Grandparent/Senior Companion Programs
- Health Care Facilities
- Home Health Supports
- Housing Support Services
- Increase Community Access
- Independent Living Services
- Infant Development Services
- Medical Specialists and Professionals
- Mobility Training
- Out-of-home respite services
- Parent Coordinated Services
- Personal Emergency Response System
- Pharmaceutical Services
- Residential Care Homes
- Respite Services – In-home
- Social/Recreational Services and Non-Medical Therapies
- Self-Determination
- Specialized Transportation
- Speech Services
- Supplemental Program Supports
- Supported Living Services
- Therapies
- Translator/Interpreter Services

Resource: https://www.dds.ca.gov/wp-content/uploads/2019/03/RC_ServicesDescriptionsEnglish_20190304.pdf

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Providers can refer Enrollees to RCs by contacting the corresponding office based on location:

Regional Center	Office Location(s)	Counties Served
Alta California Regional Center Website: www.altaregional.org	2241 Harvard Street, Suite 100 Sacramento, CA 951815 Phone: 1-916-978-6400 TTY:1-916-489-4241 Early Start Intake: 1-916-978-6249	Alpine and El Dorado
Valley Mountain Regional Center Website: www.vmrc.net	San Joaquin Branch: 702 N Aurora St. Stockton, CA 95269-2290 Phone: 1-209-473-0951 TTY: NA Early Start Intake: 1-209-955-3281 (under age 3) Lanterman Act Services: 1-209-955-3209 (over age 3)	San Joaquin and Stanislaus
	Stanislaus Branch: 1820 Blue Gum Ave. Modesto, CA 95358 Phone: 1-209-529-2626 Early Start Services: 1-209-557-5619 Lanterman Act Services: 1-209-557-2197	

TRANSGENDER SERVICES

Transgender services are a covered benefit available to D-SNP Members. Health Plan Advantage D-SNP continues to work with community partners to offer guidance, support and local resources to provide the best possible culturally sensitive care.

The basic elements available to support Providers caring for transgender Members are:

- Identification and criterion for transgender Members.
- PCP training to address the special needs of transgender candidates within Health Plan Advantage D-SNP's service area and adjoining areas.
- Training events for Provider's offices in transgender special needs and support.
- Specialists in the service area and surrounding areas for transgender care and support.

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- Hospitals specializing in the surgical needs of transgender Members.
- Continuing dialogue with transgender advocates about support, programs, and initiatives.
- 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 PCP, 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.

Enrollees 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.

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AUTHORIZATIONS

Hospital Authorizations

Facility referrals for elective inpatient service must be prior authorized by Health Plan Advantage D-SNP. After the Enrollee is admitted to the facility, the admitting Provider, including any hospitalists, will manage the Enrollee's treatment and care. Admissions to out-of-network facilities require prior authorization approval by Health Plan Advantage D-SNP's UM Department.

Health Plan Advantage D-SNP initially uses Medicare coverage rules, including NCDs, LCDs and Medicare manuals to determine the medical necessity for admission, length of stay and treatment options. For certain procedures included on Medicare's Inpatient-Only (IPO) list, Medicare coverage is limited to the inpatient hospital setting. If Medicare does not cover the procedure because of the setting, Medi-Cal coverage rules may apply.

It is imperative that the facility team Health Plan Advantage D-SNP work together to ensure that Enrollee receives appropriate care and that coverage determinations are accurate and consistent.

Hospital Emergency Admissions

Emergency admissions do not require prior authorization and are covered under the prudent layperson standard, meaning Enrollees are covered when a reasonable person would believe the situation requires immediate medical attention. Facilities should notify Health Plan Advantage D-SNP within 24 hours of admission to support care coordination, concurrent review, and discharge planning.

Clinical information should be provided to Health Plan Advantage D-SNP to support continued stay review and transitions of care. Continued stay determinations are made in accordance with Medicare coverage rules, with Medi-Cal criteria applied only when Medicare does not cover the service.

Outpatient and Ancillary Prior Authorization

Providers should consult the Provider portal for guidance on prior authorization for outpatient and ancillary services. For covered services requiring prior authorization, the requesting Provider will be notified of Health Plan Advantage D-SNP's decision to authorize or deny. Upon authorization, Health Plan Advantage D-SNP will coordinate with contracted outpatient and/or ancillary Providers.

Health Plan Advantage D-SNP's physicians and other licensed clinical staff initially applies Medicare coverage rules including NCDs, LCDs and Medicare manuals to determine the medical necessity for outpatient services. If no Medicare criteria apply, nationally recognized evidence-based guidelines such as MCG may be used as a secondary reference. If the requested service is not addressed by Medicare or MCG, Medi-Cal criteria may be applied. If no applicable criteria exist, reviewers will consult Health Plan Advantage D-SNP's internal policies and peer-reviewed, published literature to support the decision.

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If medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the requested outpatient service, the request will be denied by the Medical Director.

Prior Authorization

Health Plan Advantage D-SNP requires all covered services for physical and behavioral health conditions that require authorization be submitted to Health Plan Advantage D-SNP's UM Department for medical necessity review.

Health Plan Advantage D-SNP's physicians and other licensed clinical staff initially applies Medicare coverage rules including NCDs, LCDs and Medicare manuals to determine the medical necessity for outpatient services. If no Medicare criteria apply, nationally recognized evidence-based guidelines such as MCG may be used as a secondary reference. If the requested service is not addressed by Medicare or MCG, Medi-Cal criteria may be applied. If no applicable criteria exist, reviewers will consult Health Plan Advantage D-SNP's internal policies and peer-reviewed, published literature to support the decision.

If medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the requested outpatient service, the request will be denied by the Medical Director.