



UTILIZATION MANAGEMENT PROGRAM DESCRIPTION 2012

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I. MISSION STATEMENT

CenCal Health Mission Statement is to improve the health and well-being of people of the central coast by providing access to high quality medical services.

CenCal Health is committed to excellence through a value added Utilization Management Program.

II. AUTHORITY

The Chief Medical Officer oversees all clinical aspects of the Utilization Management Program. For all lines of business, the Primary Care Physician (PCP) is responsible for managing all aspects of the member's health care needs. To this end, all members select a PCP at the time of enrollment and are encouraged to establish a relationship with the physician as soon as possible. The member is instructed to contact his or her PCP whenever medical health care is needed. Thus, the PCP is informed about his or her patient's needs and can make informed, appropriate decisions regarding treatment.

III. PURPOSE

CenCal Health's Utilization Management (UM) Program is designed to promote the delivery of high quality, medically necessary, and cost efficient health care for our members. The program is under the administrative and clinical direction of the Chief Medical Officer (CMO). The Medical Advisory Committee evaluates and approves the Utilization Management Program annually and updates occur as needed. CenCal Health's Utilization Management Program is a component of CenCal Health's Quality Assessment and Improvement Program (QAIP) to promote the continuous monitoring and evaluation of care and services provided to our members.

IV. SCOPE OF THE PROGRAM

The scope of utilization management activities covers all clinical aspects of preventive, diagnostic and treatment services in both the inpatient and outpatient settings, which includes behavioral health, pharmacy and medical case management. A behavioral health care practitioner representing PacifiCare Behavioral Health has substantial involvement in the implementation of the behavioral health care aspects of the program for CenCal Health's non-Medi-Cal members.

V. GOALS AND OBJECTIVES

Utilization Management is performed to promote an effective and efficient medical health care delivery system. The UM program is designed to evaluate the quality and cost of medical services provided by participating physicians and other practitioners as well as facility providers and other ancillary providers. The goals of the Utilization Management Program are to promote appropriate utilization, which includes evaluation of both potential over-utilization and under-utilization.

The purpose of the UM program is to achieve the following objectives for all members:

- Support the provision of effective, efficient and appropriate utilization of facilities and services through an ongoing monitoring and educational program. The program is designed to identify patterns of utilization and ensure the efficient use of resources
- To promote fair and consistent Utilization Management decision-making
- To focus resources on a timely resolution of identified problems
- To assist in the promotion and maintenance of optimally achievable quality of care
- To educate medical practitioners, providers and other health care professionals about appropriate and cost-effective use of health care resources
- Establish, update, and approve criteria for medical necessity at least annually
- Promote consistency in authorization processing through application of defined criteria for clinical decision-making

- CenCal Health works cooperatively with its participating practitioners and providers to promote appropriate management of all aspects of members' health care
- Provide a system to monitor the delivery of medical and related services in a timely, effective and efficient manner consistent with the delivery of quality care
- Continually monitor, evaluate and optimize health care resource utilization
- Monitor utilization practice patterns of the physicians, contracted hospitals and contracted ancillary services and specialty providers
- Provide appropriate and timely feedback to members, practitioners, and hospitals to communicate reasons for treatment denial, the minimum clinical criteria required for authorization, and methods for appeal
- Safeguard medical record, treatment authorization, and all other confidential information through appropriate operational protocols and use of physical mechanisms to protect member-specific information used in UM
- Coordinate UM with quality management activities to support the ongoing monitoring of compliance with quality standards for the delivery of health services to members
- Routine review of out-of-network seldom used specialty services
- Provide annual Interrater Reliability testing of physicians and non-physician UM staff

VI. PROGRAM STRUCTURE

A. Organizational Structure

CenCal Health's Health Services Department has operational, administrative and fiscal responsibility for the Utilization Management Program. The UM Program encompasses the following programs: Medi-Cal, Healthy Families, Healthy Kids, Access for Infants and Mothers (AIM) and In-Home Support Services (IHSS). To effectively achieve program goals and objectives the UM Unit is comprised of licensed healthcare professionals, including Registered Nurses, Physicians, Health Educator, and other educated professionals.

The majority of CenCal Health members come from low-income families, comprised mostly of women and children, but also including members that are aged, blind, and/or disabled. In order to provide quality care to these members, the UM Program structure is unique and focused on these members' needs. The UM Program relies upon a multidisciplinary approach to ensure efficient delivery of health care services in the best setting suited to meet the medical and psychosocial needs of the members.

B. Authority and Accountability

The Utilization Management Program functions ultimately under direction of Chief Medical Officer, who is fully involved in the UM program implementation. Licensed and non-licensed healthcare professionals, including administrative support associates, nurses, physicians and other clinically educated professionals have authority to function within the UM Program based upon their job descriptions.

A licensed Registered Nurse, the Chief Nursing Officer/ Health Services Director has appropriate health care experience as described in a respective job description and has oversight of day-to-day Utilization Management activities and medical necessity decision making performed by designated associates within the department. The Associate Medical Director/contracted Physician Reviewer reports to the CMO. The Associate Medical Director/contracted Physician Reviewer and the CMO must meet job description requirements that include education, training or professional experience in medical or clinical practice, and must have a current license to practice without restrictions in the State of California. The CMO is responsible for Quality Operations and the Utilization Management/Care Management program development, implementation, and evaluation; participates in quality of care and

clinical grievance review processes; physician review oversight and quality monitoring; provides medical support for Health Services; performs physician case reviews; if required CenCal Health utilizes board-certified physician consultants to assist in making medical necessity determination. UM dedicated physicians and physician consultants assure day-to-day Utilization Management and other specialty UM Programs' decisions are based on medical necessity, medical appropriateness, contract provisions and covered benefits while also taking into account the needs of the individual members and characteristics of the local delivery system. UM determinations also take into account the unique, including cultural, needs of the member and capacity and capabilities of the medical delivery system.

Clinical determinations based on medical necessity are made by appropriate licensed professionals; however, decisions to deny can only be made by a physician or pharmacist. Requests for services with a benefit determination are reviewed by appropriately licensed professionals; however, decisions to deny based upon the benefit structure can only be made by a physician.

To ensure that the first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, CenCal Health has adopted standards for personnel making review decisions. The following types of personnel can perform the functions listed:

1. UM Specialists - eligibility determination, editing of referral form for completeness, interface with providers to obtain any needed non-medical information, approval of services meeting criteria (under a RN's supervision) and other clinical functions.
2. Licensed Registered Nurses perform initial review of medical information, initial determination of benefit coverage, obtaining additional medical information, as needed from providers, and approval of medically necessary referrals.
3. A designated licensed physician is responsible for all denials for medical necessity or benefit coverage and to obtain additional medical information from the treating physician as needed.

C. Committee Structure

CenCal Health's Medical Advisory Committee (MAC) is charged with responsibility for oversight for all the UM Program's activities and processes. The Chief Medical Office chairs the MAC. The Medical Advisory Committee (MAC) reports to the Quality Improvement Committee.

VII. UTILIZATION MANAGEMENT ACTIVITIES

To meet the purpose, scope and goals of the UM Program approved by CenCal Health's Board of Directors, UM activities are focused in the following areas:

1. Annual evaluation, update and approval of the UM Program Description
2. Annual update and adoption of clinical UM criteria, and the process for applying those criteria
3. Consistent application of written UM criteria to support UM decisions by qualified licensed health professionals, and the ongoing measurement of consistency in UM decisions as demonstrated through inter-rater reliability reviews
4. Timeliness of UM decisions and communication of such decisions to practitioners and, as indicated, to members
5. Participation in the evaluation of investigative, experimental or new medical technologies
6. Evaluation of Member, Practitioner, and Provider Satisfaction, with the UM process
7. Review and update of the drug formulary and procedures for pharmaceutical management to promote the clinically appropriate use of pharmaceuticals
8. Monitor and evaluate the appropriate utilization of care and services
9. Evaluate non-benefit exceptions
10. Routine review of out-of-network, seldom used specialty services
11. Make referrals to Care Management for care coordination, as appropriate

VIII. UTILIZATION MANAGEMENT PROCESS

CenCal Health's Health Services Department maintains departmental policies and procedures. These policies and procedures are reviewed annually and updated on an as-needed basis. Utilization Management decisions are based only upon appropriateness of care and service and existence of coverage. Utilization Management staff (physician and non-physician staff) are not financially or otherwise compensated to encourage under utilization and/or denials.

The Chief Medical Officer, Associate Medical Director, contracted Physician Reviewer or Pharmacists, as appropriate, are the only representatives with the authority to deny authorization or payment for a service based on medical necessity, non-benefit, or medical appropriateness.

To eliminate the fragmentation that often occurs within an unmanaged health care delivery system, the Primary Care Physician (PCP) is responsible for coordinating most aspects of the members' health care. Conversely, members may access Emergency Services, Minor Consent Services, family planning services, basic prenatal care, sexually transmitted disease services, HIV testing, and Limited Services without PCP referral or prior authorization. Regardless of the referral requirement, members are encouraged to seek their PCP's advice before seeking specialist consultation and treatment.

IX. UTILIZATION MANAGEMENT METHODOLOGY AND SUPPORT

CenCal Health uses written objective criteria based on sound clinical evidence in making utilization decisions based on medical necessity. CenCal Health's policy on the adoption and development of clinical utilization management criteria defines eligible criteria sources, and the process for development, adoption and review of clinical criteria.

In addition to application of UM criteria in decision-making, the UM Coordinators assess the unique needs of individual patients in consideration of local medical resources. The UM Coordinators gather relevant clinical information and facts from appropriate practitioners involved in a member's care. This may be accomplished through review of medical record documentation and/or conversations with appropriate physicians.

The following factors that relate to the individual must each be considered when applying clinical UM criteria:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable

CenCal Health shall utilize written UM decision-making criteria that are objective and based on sound medical evidence. Approved criteria include the following:

1. **InterQual[®] Guidelines** – includes medical literature, textbooks and nationally recognized guidelines published in all fields of medicine, practice observations and database analyses, and review by expert consultants consistent with McKesson's procedures for updating InterQual Guidelines.
2. **State and federal regulatory criteria, including the Electronic Data System (EDS) Medi-Cal Provider Manual** – includes information on Medi-Cal services, programs, and claim reimbursement. The manuals are available in their entirety free of charge on the Internet at www.medi-cal.ca.gov.
3. **The Manual of Criteria for Medi-Cal Authorization** – The Department of Health Care Services (DHCS) has established regulations governing the Medi-Cal program, which require that certain services can be authorized and paid only after appropriate professional review by a physician, registered nurse or pharmacist consultant. The review criteria published in this manual, while not exhausting the range of services covered by Medi-Cal, assists in standardizing professional judgment. The criteria themselves have been developed by medical professionals and are to be used as guidelines.
4. **Other Nationally Recognized Criteria** - From time to time a service is requested that does not have clear medical necessity criteria in any of the sources mentioned above. In these cases UM staff will refer to guidelines from national professional organizations and from large commercial health plans, such as Blue Cross www.anthem.com and Aetna whose policies and criteria are available to the public online.
5. **MedImpact's National Library of Medication Request Guidelines**
6. **HealthHelp's Imaging Criteria**

The intent of utilizing established screening and decision criteria is to promote consistency of reviews. The nurse and physician reviewers and any other associate who works in a capacity that allows him/her to apply screening and decision criteria is audited periodically, and at least annually, for interrater reliability and these results are analyzed and reported to MCC. When an opportunity for improvement is identified, an action plan is initiated by the appropriate CMO and/or UM Manager to track resolution.

X. UTILIZATION MANAGEMENT OPERATIONAL DESCRIPTION

A. Scope of Program Activities

The Utilization Management Program's scope is comprehensive, systematic and ongoing. The Program includes associates and management who oversee UM activities and supervise all review decisions. The unit includes associates who perform pre-service, concurrent, and post-

service review, as well as other specialty UM Programs.

UM processes support confidentiality of patient-specific information obtained during UM activities. Any patient-specific information obtained is kept confidential in accordance with applicable laws; is used solely for the purposes of Utilization Management, Quality Management, disease management, discharge planning, claims payment facilitation; is shared only with those entities who have authority to receive such information; and shared only with those individuals who need access to such information in order to conduct Utilization Management and related processes.

The UM Program provides communication services for practitioner and members that include:

1. Availability of UM staff for at least 8 hours a day during normal business days (Monday-Friday, excluding holidays) for inbound calls regarding UM issues.
2. Ability of UM staff to receive inbound communication after normal business hours regarding UM issues via fax and/or confidential voice mail.
3. Outbound communication from UM staff regarding inquiries about UM during normal business hours (Monday-Friday, excluding holidays), unless otherwise agreed upon.
4. UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
5. UM staff, upon request from the caller, provide Utilization Management requirements and procedures.
6. A toll-free number.
7. Access to appropriate UM staff for callers with questions about the UM process.

B. Utilization Management Review Processes

The Utilization Management Program includes Utilization Management (UM) operations and activities that are conducted by qualified UM staff with the appropriate experience and expertise. UM clinical review is performed by health care professionals who possess an active professional license or certificate. Pre-established decision criteria are used to assist in Utilization Management decisions regarding requests for healthcare or other covered benefits.

When making a determination of coverage based on medical necessity, the designated UM reviewer obtains relevant clinical information and consults with the treating physician, as necessary. Authorization and notification of decision for proposed services, referrals, or hospitalizations at the practitioner level involves utilizing information such as medical records, test reports, specialists' consults, and verbal communication with the requesting practitioner in the review determination. Part of this review process is to determine if the service, whether seldom used or an unusual specialty service, is available in network. If the service is not available in network, arrangements must be made for the member to obtain the service from a non-network provider for this episode of care. The Chief Medical Officer is involved when specialty services from specialists outside the network are to be arranged.

When non-clinical administrative staff is utilized to pre-screen requests for service, a licensed health professional oversees this process. The non-clinical staff may review requests for completeness and collect non-clinical and structured clinical data; however, they do not evaluate or interpret clinical information.

If the designated UM reviewer agrees that the request is clearly medically necessary and is a covered benefit, an appropriate authorization is provided. However, when the reviewer questions the appropriateness of the request, a review referral may be made to the designated CenCal Health physician or specialist, if appropriate. Additionally, UM reviewers have access to physician consultation, as necessary. At no time are decisions made by any staff member,

clinical reviewer or physician that is based on financial incentives or involve a conflict of interest. All decisions to not authorize or deny a request can be made only by a UM physician.

The following is a brief description of the various UM processes that may be incorporated, as necessary, when a member has been referred to the Utilization Management Program:

1. Pre-service Review

Is a process of review in which clinical information and requests are reviewed to determine medical necessity prior to rendering services. Review determinations are based on the medical information obtained at the time of the review. CenCal Health informs providers about the procedures and services that require prior authorization, including the timeframes necessary to obtain prior authorization, through the provider manual and Provider Bulletin. Requests for pre-service review may include but are not limited to, elective inpatient hospitalizations, outpatient procedures, diagnostic procedures, therapy services, and durable medical equipment requests. Prior Authorization requirements shall NOT be applied to:

- a. Emergency services,
- b. Family planning services,
- c. Preventive services
- d. Basic prenatal care,
- e. Sexually transmitted disease services, and
- f. HIV testing.

2. Concurrent Review

A process of initial and ongoing review of hospitalizations, as well as the initial extension of ambulatory services (including but not limited to acute care facilities, skilled nursing facilities and acute rehabilitation facilities, home health, etc.), through communication with physicians and other member-assigned healthcare professionals, as well as communication with the member/authorized representative, as appropriate.

This communication process takes place by telephonic review and electronic review or an onsite review at facilities by UM Nurses. The process incorporates the use of pre-established decision criteria in order to approve appropriate medically necessary care and assign the most appropriate level of care for continued medical treatment. Review determinations are based on the medical information obtained at the time of the review.

3. Post-service Review

A process consisting of obtaining medical information to determine medical necessity as it relates to services that have been provided when there has been no notification or request for review during the pre-service or concurrent process or when clinical information was not available at the time services were being rendered. Medical records are required for the post-service review process. Review determinations are based solely on the medical information available.

4. Discharge Planning

A process that facilitates coordination of ongoing care, whether at a lower level of inpatient care or in the home with home care services. Discharge planning supports continuity of care and efficient use of resources, and incorporates the involvement and decision-making process with the member and significant other(s). The process begins at the time of admission, and is coordinated by the facility's discharge planner. CenCal UM nurses support the facility's discharge planning arrangements.

5. Second Medical Opinion

CenCal Health allows second medical opinion upon request of a patient or a participating health professional treating a patient. The second medical opinion must

be provided by an appropriately qualified health care professional at no cost to the member.

6. Emergency Department Services

CenCal Health's provider agreements specify provisions for coverage of emergency services necessary to screen and stabilize members without preauthorization in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

No referrals are required for treatment of an emergency condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably be expected to result in the following:

- Placing the health of the member, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy
- Serious impairment to bodily function
- Serious dysfunction of any bodily organ or part

Emergency Department services are also covered if referred by an authorized CenCal Health representative, a PCP or network specialist. Notification to CenCal Health is not required for payment of Emergency Department services for an emergency medical condition.

7. Out of Network (Out of Plan)

When required, requests for out of network services are reviewed by CenCal Health individually and determinations are made based on the member's medical needs and the availability of services within CenCal Health's practitioner and provider network to meet these needs.

8. Tertiary Care Services

The member's medical needs and the availability of the requested services from CenCal Health's in-network tertiary care centers and in-network non-tertiary care providers are taken into consideration. If such a request is considered for denial, the Chief Medical Officer or Associate Medical Director considers the network specialist's recommendations prior to making a coverage determination. It is important that the member's PCP agrees with the request to use a tertiary care center.

XI. PROMOTING APPROPRIATE UTILIZATION - MONITORING UNDER- AND OVER- UTILIZATION

CenCal Health's UM decision-making is based only on appropriateness of care and service and existence of coverage. CenCal Health identifies any significant variance from the standard of care, either as a sentinel event if an unjustifiable adverse outcome warrants immediate action or based on a pattern of practice that falls significantly outside of the established program and community standard. Levels of analysis include MCO-wide, and product line, to identify over or under-utilization. More detailed analyses are conducted as warranted to investigate and resolve identified problems.

Performance comparisons are made against benchmarks or goals and historical norms. Established methodologies are used for measurement purposes to every extent possible. When UM concerns are identified, an action plan is required to be established by the appropriate quality improvement committee. Such action plans may include provider education, member education, staff development, administrative changes, provider contract changes and/or alteration of provider privileges. The scope of each action plan is determined based on the circumstances and identified causes that relate to each unique adverse outcome or variance from standard. The scope of each

action plan is approved by the appropriate CenCal Health quality improvement committee, which assures that interventions are timely and meaningful. Re-measurement is performed at appropriate intervals to determine the effectiveness of interventions.

XII. DELEGATED UTILIZATION MANAGEMENT

When Utilization Management is delegated to another entity, the Utilization Management operations and activities are conducted by qualified UM staff who must meet job description requirements that include education, training, or professional experience in medical or clinical practice and must have a current California license to practice without restrictions. Pre-contractual audits occur to assess whether key components are in place to ensure that the entity will adhere to CenCal Health requirements. Each delegated organization must have a Utilization Management Program that is approved annually by CenCal Health's Delegation Oversight Committee, as well as a signed Delegation Agreement in place. Each delegation agreement details the key components, processes and reporting requirements of the delegate.

XIII. PHARMACY SERVICES

a. Prescription Drug Utilization Management

CenCal Health utilizes MEDIMPACT as its Pharmacy Benefit Manager (PBM). Quantity limits, step therapy and prior authorization (criteria established by the Pharmacy and Therapeutics Committee) are placed on certain drugs. The utilization management process is activated when the network or community pharmacist submits a prescription for a member. The PBM staff collects all pertinent medical information and has the authority to approve coverage if criteria are met. All other determinations are made by the Chief Medical Officer, Associate Medical Director/contracted Physician Reviewer, or the Director of Pharmacy Services, who is a Pharm.D. All UM processes, including verbal and written notification of the decision to the practitioner and member are followed in making a denial determination

b. Drug Formulary Use

CenCal Health follows established policies and procedures regarding drug formulary use. CenCal Health's policies and procedures specify that the formulary be:

- Based on sound clinical evidence from appropriate external organizations
- Clearly documented, and that the application of pharmaceutical management procedures is based on identified member needs
- Developed with input from appropriate actively practicing practitioners
- Reviewed at least annually and updated based on established criteria that governs pharmaceutical management decisions for therapeutic classes, and medications within classes
- Made available to its practitioners annually, including all pharmaceutical management procedures

CenCal Health has an established process by which members and practitioners may request non-formulary drugs. Likewise, a process exists by which members and practitioners may appeal denied requests for non-formulary drugs.

XIV. BEHAVIORAL HEALTH SERVICES FOR MEDI-CAL MEMBERS

Behavioral Health is a carve-out for Medi-Cal members. The procedure for referral of Medi-Cal members is as follows:

- PCPs provide outpatient behavioral health services within their scope of practice
- PCPs refer Medi-Cal members to the county behavioral services department for evaluation and coordination of medically necessary specialty behavioral health services including psychiatric inpatient care
- PCPs refer Medi-Cal members to qualified Medi-Cal Providers for the provision of behavioral health services not covered by the county behavioral services department.

CenCal Health and its providers, adhere to all requirements and provide coverage for services as outlined in the State of California MMCD Letter 00-01 dated • March 16, 2000, including but not limited to:

- Medical Transportation
- Hospital Outpatient Department Services
- Targeted Case Management
- Exchange of Medical Records
- Confidentiality Procedures with the Mental Health Plan and other Providers of Mental Health
- Coordination of Discharge Planning from inpatient facilities

XV. BEHAVIORAL HEALTH SERVICES FOR NON-MEDI-CAL MEMBERS

PacifiCare Behavioral Health of California (PBHC) is the Managed Behavioral Health Organization (MBHO) to whom CenCal Health has delegated the provision of behavioral health services to non-Medi-Cal members. PBHC is accredited by the National Committee for Quality Assurance (NCQA) and/or URAC and submits regular reports to CenCal Health for oversight. To the extent possible and permissible by current privacy and confidentiality regulations, behavioral health and general medical management is integrated for optimal health outcomes.

The procedure for referral of Healthy Families (HF), Healthy Kids (HK) and Access for Infants and Mothers (AIM, formerly PP2) members is as follows:

- PCPs, other physicians and practitioners refer members of the above programs to the county behavioral services department for determination of Severely Emotionally Disturbed (SED) status. The county behavioral services department documents response to CenCal Health and the referring party via an established form. For non-SED behavioral health requests, PCPs, other physicians and practitioners refer members of the above programs to practitioners participating with CenCal Health's MBHO. CenCal Health's MBHO performs utilization management, appropriate coordination of care and quality management activities.

The procedure for referral of IHSS Healthcare members is as follows:

- PCPs may refer to an IHSS network behavioral health provider for outpatient behavioral health services and/or may admit members to a contracted facility for inpatient behavioral health services. There are no service limitations for members with behavioral health conditions classified as Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI).

XVI. CARVED-OUT AND LINKED SERVICES FOR MEDI-CAL MEMBERS:

Some services for the Medi-Cal members are carved out as described in Evidence of Coverage (EOC). Members may also be linked to other services such as CHDP, waiver programs and Regional Centers. Members are referred to their PCP to conduct Initial Health Assessments and coordination of referrals to specialists, ancillary services and linked services as needed. CenCal Health UM/CM staff may assist the provider making referrals and in locating necessary linked and carved-out services. CenCal Health ensures that all Medi-Cal members will have access to appropriate covered services for vision care and dental care through its delegated vendors. Members in need of these services are referred to the appropriate vendor who is responsible for provision of these services.

XVII. DEPARTMENTAL STAFFING

Staffing

The Health Services team may include the positions described below:

Chief Medical Officer

The Chief Medical Officer's accountability objective oversees the development or revision and implementation of the UM Program. The Chief Medical Officer is responsible for providing clinical support, exercising professional judgment on issues of medical necessity, and overseeing staff's application of appropriate treatment protocols to utilization management decision-making.

Associate Medical Director /contracted Physician Reviewer

The Physician Reviewer's accountability objectives may include oversight and decision making in all areas of preauthorization, medical appropriateness of selected procedures, concurrent and retrospective reviews as assigned by the CMO.

In the absence of the Chief Medical Officer, the Associate Medical Director/contracted Physician Reviewer functions as the Chief Medical Officer as assigned by the Chief Executive Officer.

Director of Health Services

The Director of Health Services is a California licensed Registered Nurse or similarly licensed professional. The Director of Health Services' accountability objective is to manage the Health Services Department to provide ongoing, effective and efficient assessment of all aspects of care and services to help support the coordinated delivery of high quality, safe, cost-effective medical care to all CenCal Health members.

Director of Pharmacy Services

The Director of Pharmacy Services is a California licensed pharmacist. The Director's accountability objective is to manage the Pharmacy Services Department to maintain a formulary which promotes optimal efficacy, safety, and cost-effectiveness of drug therapy for all CenCal Health members.

Clinical Manager

The Health Services Clinical Manager is a Registered Nurse who is responsible for assisting the Director of Health Services and Chief Medical Officer in managing the Utilization Management Review Process of Pre-Service Review; Concurrent Review; Post-Service Review; Discharge Planning; Second Medical Opinion; Out of Network (Out of Plan); and Tertiary Care Services and assists the CMO with monitoring Under- and Over-Utilization. This position also supervises the staff Utilization Management Coordinators including providing training to the Utilization Management staff and ensuring inter-rater reliability. The Clinical Manager is also the point person for all questions from network providers and out of plan providers about the Utilization Management Process including the necessary documentation required to have services rendered to CenCal members.

Quality Improvement Manager

The Health Services Quality Manager is a Registered Nurse who is responsible for assisting the Director of Health Services and Chief Medical Officer in managing quality within the department, to ensure that all metrics are met, potential quality of care issues are investigated, ensuring compliance with Department of Health Care Services (DHCS) requirements with regards to facility site and medical record reviews, reviewing data provided by other departments to identify opportunities for improvement within Health Services, developing, implementing, and reviewing quality improvement programs, and assisting with update of annual work plan. This position assists the CMO with the Peer Review Committee work, as well as making quality presentations at other committees such as Medical advisory and Quality Improvement committees.

Health Services Quality Management Coordinator

The Health Services Quality Management Coordinator is a Registered Nurse whose accountability objective is to coordinate and perform facility site audits, medical record reviews, including reviews for potential quality of care issues. .

UM Coordinators

A UM Coordinator is a Registered Nurse who is responsible for evaluating the medical appropriateness of services within the scope of benefits of CenCal Health's programs. UM Coordinators review preauthorization, concurrent, and retrospective requests for all types of non-pharmacy services, including preadmission, concurrent and retrospective inpatient admissions, home health care, and ambulatory care using approved criteria in their decision-making process. The UM Coordinators also identify and refer members for potential Care Management intervention and collaborate with the Quality Management unit by making referrals regarding suspected quality of care issues to a Quality Management Coordinator. The UM Coordinator acts as an interdepartmental liaison to support prompt resolution of acute care and long term care and ambulatory care issues and questions.

Senior Health Promotion Educator

The Health Educator is a professional with a Masters Degree in Public Health (MPH) who is

responsible for the health provision and member education activities, assessing the health needs of CenCal Health's member population, and participation in community coalition's collaborative efforts for health promotion within the member population, and to ensure member materials are within State mandated reading levels.

UM Specialist

The UM Specialist works under the direction and supervision of a Registered Nurse to facilitate requests for durable medical equipment used in the ambulatory care setting. Using approved criteria, the UM Specialist reviews requests for DME, orthotics, prosthetics and hearing aids.

Intake and Support Specialist

The Health Services Specialist working under the direction of a Registered Nurse facilitate requests for ongoing skilled nursing facility long term care stays, non-emergent routine ambulance requests, assists with claims issues, and assists providers with basic questions regarding TARs/RAFs.

XVIII. COMMUNICATION SERVICES/TIMELINESS OF UM DECISIONS

CenCal Health follows the following decision and notification timeframes for all utilization management determinations.

Decision Timeframes	Medi-Cal Contract 200-2010	Non-Medi-Cal H&S Code 1367.01
<u>Emergency Care</u>	No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.	Same
<u>Post-stabilization</u>	Upon receipt of an authorization request from an emergency services provider, UM shall render a decision within 30 minutes or the request is deemed approved, pursuant to Title 28 CCR Section 1300.71.4. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.	Same
<u>Concurrent Review of authorization for treatment regimen already in place</u>	Within 24 hours of the decision, consistent with urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01 (h)(3).	Same
<u>Retrospective Review</u>	Within 30 calendar days in accordance with Health and Safety Code Section 1367.01(h)(1).	Same

Decision Timeframes	Medi-Cal Contract 200-2010	Non-Medi-Cal H&S Code 1367.01
<u>Pharmaceuticals</u>	24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).	Same
<u>Therapeutic Enteral Formula for Medical Conditions in Infants and Children:</u>	Timeframes for Medical Authorization of Medically Necessary therapeutic enteral formulas for infants and children and the equipment/supplies necessary for delivery of these special foods are set forth in MMCD Policy Letter 07-016, Welfare and Institutions Code Section 14103.6 and Health and Safety Code Section 1367.01.	Same
<u>Routine Authorizations</u>	Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or CenCal Health can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	Same

Decision Timeframes	Medi-Cal Contract 200-2010	Non-Medi-Cal H&S Code 1367.01
<u>Expedited Authorizations</u>	For requests in which a provider indicates, or UM determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, UM must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than three (3) working days after receipt of the request for services. UM may extend the three (3) working days time period by up to 14 calendar days if the Member requests an extension, or if CenCal Health justifies, to the DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	Same

Communication of Review Decisions

CenCal Health's UM Staff notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Approvals may be communicated orally, but denials/modification decisions are always sent in writing, via letter. If the denial/modification is one involving a pre-service request, the member will also be notified in writing, via letter.

XIX. DENIALS, APPEALS AND GRIEVANCES

Denials are based on benefit coverage, medical necessity and are often due to the lack of sufficient clinical information being provided by the physician, practitioner, or faculty. Only CenCal Health physicians can issue a denial decision. Attempts to reach the treating physician are often made prior to issuing denials and CenCal Health physicians are always available to discuss the denial with the practitioner. Denial decisions are communicated verbally and in writing as required by contract.

A qualified physician reviews and performs all TAR/RAF denials. All CenCal Health physicians who review and perform denials demonstrate education, training or professional experience in medical or clinical practice prior to employment by CenCal Health. When one of CenCal Health's qualified physicians does not have applicable expertise to assess the medical necessity of a requested service, the Chief Medical Officer or Associate Medical Director/contracted Physician Reviewer directs review by an appropriately licensed professional. A qualified physician reviews all denials of requests for prior authorization.

Denial notifications include:

- A clear, concise and specific explanation of the reasons for the plan's decision
- A reference to the criteria or guidelines used as a basis for the plan's decision, and notice that upon request the member and/or provider can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion upon which the denial decision was based

- Other clinical reasons used as a basis for a decision regarding medical necessity that are easily understood and do not contain abbreviations
- The name and direct telephone number and extension of the physician or pharmacist responsible for the decision (for written or electronic communications to providers only)
- Information on how the member and/or provider may file an appeal with the plan, and when applicable, request an administrative hearing

Appeals

CenCal Health's Health Services Department participates in the thorough, appropriate and timely resolution of clinical appeals.

CenCal Health has procedures in place for timely response to pre-service, post-service, and expedited appeals. These procedures are detailed in Member Services P&P 300-1000: MEMBER GRIEVANCE SYSTEM (COMPLAINTS/APPEALS).

CenCal Health will appoint a physician not involved in the prior adverse decision to review the appeal. The appointed person must be neither the individual who made the adverse determination that is the subject of the appeal nor a subordinate of (i.e., directly supervised by) such individual.

XX. EVALUATION OF NEW TECHNOLOGY, EXPERIMENTAL AND INVESTIGATIVE

To keep pace with technological change and to ensure that members have equitable access to safe and effective care, CenCal Health has a process to evaluate and address new developments in medical technology as well as their application to CenCal Health's member populations.

In order to decide whether to include new technologies (e.g. medical, pharmaceutical, devices and behavioral health procedures), CenCal Health reviews appropriate information from scientific evidence and regulatory bodies as part of its decision-making process. CenCal Health uses licensed clinical professionals in the evaluation of each new technology. In addition, CenCal Health staff, in consultation with practitioners of appropriate specialties and expertise in the technology, develops the clinical criteria used to authorize or deny use of newly adopted technologies.

XXI. INTER-RATER RELIABILITY

CenCal Health shall perform ongoing inter-rater reliability (IRR) analysis in order to evaluate the consistency with which physicians and non-physicians involved in the Utilization Management (UM) processes apply approved clinical criteria. The McKesson InterQual® IRR Tool will be utilized for the IRR process. On an annual basis, the Medical Advisory Committee shall receive an aggregate report noting the summary of IRR findings.

XXII. INTEGRATION WITH QUALITY MANAGEMENT

The UM Program has a variety of quality operations processes in place to ensure quality of care service-oriented interventions are initiated and carried out. Key performance and quality of care indicators and criteria are established in collaboration with the QIC Committee and incorporated into the UM Program. Linkage between the UM Program and Quality Management is supported through committee by UM on multiple committees.

Additionally, UM integration with quality operations supports activities to capture utilization trends or patterns and is measured. The results are compared with nationally recognized thresholds for under and over utilization. Areas considered for potential review of utilization trends could be but would not be limited to those listed below:

- a. Inpatient Utilization
- b. Selected Procedures
- c. Referrals to Specialists

d. HEDIS Results

Where results fall outside of the thresholds, a qualitative analysis of causes is conducted. Interventions are designed and implemented to promote improved outcomes and measures. After a sufficient amount of time has passed, the effectiveness of the intervention is evaluated through re-measurement. All findings and re-measurements are reported to the MAC and the QIC.

Finally, the Utilization Management Program staff refers identified potential quality issues for review to the Chief Medical Officer.

XXIII. SATISFACTION WITH THE UM PROCESS

Practitioner and provider surveys are conducted annually to assess satisfaction with CenCal Health's UM processes, and member surveys are conducted periodically to assess UM satisfaction. Through CenCal Health's member and provider complaint and appeal process, CenCal Health continually evaluates the UM program to ensure that difficulties are not encountered when members are seeking care and when practitioners are requesting care. The Medical Advisory Committee reviews data at least annually to identify opportunities and develop interventions for improvement.

Additionally, CenCal Health surveys members annually to evaluate consumer satisfaction with several aspects of plan operations, including utilization management. This evaluation quantitatively measures member satisfaction with CenCal Health's utilization management program, which enables CenCal Health to identify and act upon opportunities to improve quality of service and/or care. The CAHPS survey provides a rich source of information that complements that which CenCal Health obtains from practitioners and providers. Together these data enable staff to annually perform a robust assessment of UM satisfaction

XXIV. EVALUATION OF THE UTILIZATION MANAGEMENT PROCESS

As part of CenCal Health's annual assessment of the Quality Assessment and Improvement Program, CenCal Health has a process for continuously reviewing the quality of care, performance of medical personnel, and utilization of services. The evaluation process includes ongoing assessment of the consistency with which UM criteria are applied by UM staff, evaluation of complaints and assessment of complaint trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to appropriate CenCal Health staff and contracting providers, and the evaluation and verification of corrective actions.

The UM Program is evaluated and approved annually. After review and approval of the annual UM Program Evaluation, the results are reported to CenCal Health's Board of Directors by the Quality Improvement Committee.

The evaluation of the UM Program will include but is not limited to an evaluation of effectiveness in:

- Resolving utilization and benefit issues, including but not limited to denials and appeals related to utilization decisions
- Creating and reviewing policies and procedures related to utilization management
- Monitoring trends and patterns of key utilization management indicators for over-and under-utilization and appropriateness of care
- Requesting studies, if applicable, on areas identified from data review as having the potential for affecting the outcomes of care and related quality concerns
- Making referrals to the QM unit for investigation of potential quality of care issues discovered during processing of coverage requests
- Clinical information & criteria used for UM Decisions

XXVI. HEALTH EDUCATION PROGRAMS

The goal of the health education program is to provide CenCal Health members with information on good health practices, preventive services, disease management and community resources. The Health Promotion Educator oversees the plan's health education activities and is responsible for planning, organizing, implementing, and evaluating health education resources and services. In addition, the Health Promotion Educator assists our provider network with education and resources and participates in coalitions and projects to promote quality health services to our members.

Health education programs are developed based on membership demographics, disease prevalence and health plan priorities based on member and provider needs. CenCal Health evaluates its health education programs and activities through analysis of member utilization data and outcomes, HEDIS rates where applicable, and/or other survey tools.

Prenatal/Postpartum Education

In 2010, CenCal Health became an Outreach Partner of a new national program called **textforbaby**, an educational program of the national Healthy Mothers, Healthy babies Coalition. We began promotion to our members and providers in August 2010 and will continue through 2011. The program provides pregnant and new moms with health information delivered to their mobile phones. Women who sign up for the free service receive text messages each week, timed to their due date or baby's date of birth, up until the 1st birthday. Enrollment data will be tracked locally, while the program is evaluated on a national level.

Smoking Cessation

CenCal Health provides smoking cessation benefits including nicotine replacement therapy and physician prescribed pharmaceuticals for members who wish to quit smoking. The Health Promotion Educator collaborates with county-sponsored tobacco prevention programs and the California Smokers Helpline to promote member access to behavior modification programs. CenCal Health established a scholarship program to provide free smoking cessation classes to members wanting to quit smoking. Member education includes an annual article in the member newsletter and smoking cessation program information in CenCal Health's community resource guide. A Provider Information Sheet is distributed to providers and an annual article is placed in the Provider Bulletin to raise awareness of these benefits and promote referrals from providers.

XXVII. CONFIDENTIALITY

Individuals engaged in the UM Program activities shall maintain confidentiality of all member information and any other information developed or presented as part of the Program. CenCal Health protects the confidentiality of member information in such a manner that is consistent with divulging or collecting only enough information from the member, subscriber or appropriate healthcare provider, that is necessary to conduct business activities. Activities and documents that are part of the UM Program are considered confidential and are maintained in compliance with legal requirements.

ACKNOWLEDGMENT AND APPROVAL

This Utilization Management Program document may be amended by a majority of the

_____ or upon the recommendations of the _____

Committee.

The _____ has reviewed, approved and adopted this document with revisions at its
_____ meeting.

Approvals:

Print Name: : _____

Signature: _____

Date _____

Print Name: : _____

Signature: _____

Date _____