

SBHI/SLOHI
UTILIZATION MANAGEMENT PROTOCOLS FOR HOSPITALS

1 **INTRODUCTION**

This Utilization Management Protocols document represents a compilation of criteria and procedures which apply to those medical and hospital services provided to Medi-Cal Members, who are enrolled in the Santa Barbara Health Initiative (SBHI) and San Luis Obispo Health Initiative (SLOHI) programs administered by CenCal Health for residents of Santa Barbara and San Luis Obispo (SLO) Counties.

CenCal Health will only reimburse Hospital for those Covered Services provided to SBHI and SLOHI Medi-Cal Members (“Members”) that are properly authorized by CenCal Health's Health Services Department. Authorization requirements are designed to ensure that CenCal Health funds are spent only on those services that are both covered by the Medi-Cal program and judged to be medically necessary in accordance with Medi-Cal guidelines, CenCal Health’s contract with the State and CenCal Health policies.

The criteria and procedures included in these Protocols have been developed by medical and medical administrative professionals who are fully aware of the vast range of medical and medical administrative problems that providers and Members encounter.

2 **REGULATORY AUTHORITY**

Through the State of California, CenCal Health has been granted waivers to existing Medicaid regulations by the Federal Health Care Financing Administration which permit the design of a unique utilization control system. Special State legislation, Welfare and Institutions Code, § 14499.5, enables CenCal Health to enter into a contract with the State for the purpose of arranging for the provision of Medi-Cal covered services to eligible Santa Barbara and SLO County residents in exchange for an agreed-upon allocation of State funds. Together, both Counties will be referred to as Service Area for purpose of these Case Management Protocols.

The State contract allows CenCal Health to develop utilization processes to ensure that medically necessary services are being provided to Members. CenCal Health normally provides Utilization Management (UM) functions, including the use of Referral Authorization Forms (RAFs) and requiring the use of Treatment Authorization Requests (TARs) when needed. (See also the AUTHORIZATIONS section of this Provider Manual).

The "Manual of Criteria for Medi-Cal Authorization" (as revised from time to time and as applicable to the particular period in which Hospital renders services) is used within this Protocol as a basic guideline for required documentation, determination of medical need criteria, and other facets of the utilization review process, in accordance with State Medi-Cal program regulations.

3 PROGRAM GOAL AND OBJECTIVES

The goal of CenCal Health's UM program is to assure the provision of appropriate and cost-effective, high-quality patient care to Members who are residents of CenCal Health's Service Area. More specifically, the programs are designed to:

- 3.1 Monitor primary care case management;
- 3.2 Increase access to health care of acceptable quality to Members;
- 3.3 Increase physician participation;
- 3.4 Introduce, for Medi-Cal Members, a provider incentive for managing a budgeted health system;
- 3.5 Improve claims processing;
- 3.6 Reduce unnecessary paperwork; and
- 3.7 Establish local program administration.

4 CENCAL HEALTH STAFFING FOR REVIEW OF SERVICE AUTHORIZATION REQUESTS AND SERVICES RENDERED

All reviews of requests for service authorizations and medical appropriateness of services rendered or denied by Hospital will be performed by CenCal Health's Health Services Department. Staff reviewing and/or overseeing the UM process includes: (i) the Medical Director and/or Associate Medical Director (hereafter both are "Medical Director"); (ii) Director of Health Services; and (iii) professional Utilization Management Coordinators ("UMC"). The Medical Director is a physician with substantial experience in the administration of utilization management programs. The Director of Health Services and the UMCs are Registered Nurses or higher level medical professionals with broad backgrounds in the implementation of utilization management protocols. A UMC may approve any request for a prior service authorization. The Medical Director shall review any UMC recommendation regarding the denial of a request for a prior service authorization.

5 EFFECTS OF CENCAL HEALTH'S SERVICE AUTHORIZATIONS

Once a service has been authorized, CenCal Health shall not retroactively deny payment for said service, unless the Member was not eligible for Medi-Cal at the time services were rendered.

6 GENERAL CRITERIA FOR ACUTE HOSPITAL CARE

A Member requires acute hospital care in the following general circumstances:

- 6.1 The Member requires or will require the constant availability of a physician and/or other medical consulting staff;
- 6.2 The Member requires immediate availability of other diagnostic and/or therapeutic services and equipment that are only available in the acute

care setting (i.e. operating room services, respiratory therapy, I.C.U. services, certain laboratory and x-ray therapies and treatments); **and**

- 6.3 The Member requires the constant availability of professional nursing services which are found in an acute hospital.

7 AUTHORIZATION OF ACUTE CARE HOSPITAL NON-EMERGENCY ADMISSIONS

- 7.1 Requirement for Prior Authorization. All non-emergency admissions to Hospital must be authorized by a Treatment Authorization Request ("TAR" or "50-1 Form") sent by a contracting physician to CenCal Health's Health Services Department at 4050 Calle Real, Santa Barbara, CA, 93110, Telephone: (805) 685-9525 or (800) 421-2560, or CenCal Health will not be obligated to reimburse Hospital.
- 7.2 Criteria and Procedures for Prior Authorization. The Member's physician must request hospital admission authorization through the TAR process, or agree to permit another contracting physician to do so by executing a physician Referral Authorization Form, or RAF, prior to any elective admission of a Member. The procedures for elective admission authorizations are as follows:
- 7.2.1 The contracting physician shall request admission authorization through the TAR process and shall provide all necessary medical information detailing the Member's medical need for inpatient services. This will be done on a 50-1 Form sent to CenCal Health's Health Services Department by the contracting physician.
- 7.2.2 The contracting physician shall provide CenCal Health's Health Services Department with a descriptive diagnosis (with accompanying ICDM-9 code), a detailing of required services with appropriate procedure codes, and any appropriate additional information that may be required to establish medical necessity for the acute hospital admission.
- 7.2.3 The completed 50-1 Form, RAF from the PCP, if required, and attached medical information, as submitted by the contracting physician, shall be reviewed by Utilization Management Staff, and a decision to approve or defer for further information, or a decision by the Medical Director to approve with modification or deny the request will be made and conveyed to the contracting physician.
- 7.2.4 After review of the medical information provided, a determination will be made on the facts of each specific case. The initial length of stay will be approved by CenCal Health's Health Services Department and noted on the 50-1 Form.

7.2.5 The original 50-1 Form will remain in the CenCal Health's Health Services Department's files to be matched with returned copies from providers.

8 GENERAL CRITERIA FOR ACUTE CARE HOSPITAL EMERGENCY ADMISSIONS
An emergency admission is one in which it is reasonable to expect that failure to admit will result in the death, disability, or continued suffering of a Member who is experiencing severe pain, as well as possibly causing the exacerbation of the Member's condition. Admissions to Hospital for any other reason are considered to be elective admissions and shall therefore require prior authorization.

9 AUTHORIZATION OF ACUTE CARE HOSPITAL EMERGENCY ADMISSIONS

9.1 Requirement for Notification of Emergency Admissions

In the event that Member's condition is an emergent condition as defined in Section 8 of this document, contact with the Member's PCP may be delayed until the Member's medical condition is stabilized. Hospital shall use its best efforts to contact the Member's PCP regarding an emergency admission within twenty-four (24) hours of the time of admission. Documentation of such contact shall consist of the time of contact and name of the person contacted, and this information shall be noted on the appropriate Extension of Stay Form ("18-1 Form") by Hospital Utilization Review ("UR") staff. Failure of Hospital to use its best efforts to contact the Member's PCP and failure of Hospital to document such efforts may result in CenCal Health's denial of payment for services rendered.

9.2 Procedures for Review of Emergency Admissions.

9.2.1 Hospital shall present medical information either electronically or on an 18-1 Form to the UMC at the next weekly UMC onsite review for each Member admitted to Hospital in an emergent condition. The UMC shall review the attached medical information and shall make an appropriate recommendation, subject to review by the Medical Director.

9.2.2 Documentation required. UR staff at Hospital will document the Member's entire stay on an 18-1 Form and provide the Member's medical record if such record is requested by the UMC.

9.2.3 Retroactive Approval of Admissions. Pursuant to 22 CCR § 51003, retroactive approval of admission may be granted under the following conditions:

9.2.3.1 When certification of the Member's eligibility was delayed;

9.2.3.2 When "other coverage" (e.g., Medicare or other health insurance programs) denied payment of a claim for services;

9.2.3.3 When communication with CenCal Health's Health Services Department staff could not be established and

provision of the required services should not have been delayed;

9.2.3.4 When a patient does not identify himself/herself to Hospital as a Member by deliberate concealment or because of physical or mental incapacity to identify himself/herself; **or**

9.2.3.5 When a natural disaster has damaged facility records and interfered with the TAR process, or other circumstances that have been reported to law enforcement or fire department personnel.

10 GENERAL CRITERIA FOR EXTENSION OF HOSPITAL STAY

General reasons for an extension of the initial length of stay common to all disorders may include, but are not limited to:

- 10.1 Continuation of conditions originally necessitating admissions;
- 10.2 Serious side effects or adverse reactions to drugs, procedures, or therapies;
- 10.3 Wound infection, separation, or hemorrhage requiring acute care;
- 10.4 Need for continuous intravenous and other parenteral fluids or medications that cannot be provided in the home;
- 10.5 Pain requiring parenteral pain controlling substances that cannot be provided in the home;
- 10.6 Pulmonary complications, pneumonias, atelectasis, respiratory insufficiency, pneumothorax, etc.;
- 10.7 Cardiovascular complications, CHF, pulmonary emboli, acute myocardial infarction, severe arrhythmias, etc.;
- 10.8 Urinary complications, retention, infection;
- 10.9 Gastrointestinal complications, ileus, bowel obstruction, uncontrolled vomiting, or diarrhea;
- 10.10 Neurological complications, impaired consciousness, loss of neuromuscular control, etc.;
- 10.11 Injury or failure of any major organs; or
- 10.12 Other acute complications.

11 AUTHORIZATION FOR EXTENSION OF STAY FOR ALL ACUTE CARE HOSPITAL ADMISSIONS

- 11.1 Documentation Required. Justification for extension of acute hospital stay beyond the initial length of stay authorized by CenCal

Health's Health Services Department must be appropriately documented by the attending physician and entered into the Member's medical record. This applies to all admissions.

11.2 Required Procedures:

- 11.2.1 It is the Hospital's responsibility to have its UR staff monitor a Member's level of care on a regular basis and for the UR staff to provide updated medical record information pertinent to the Member's medical condition as delineated in Section 11.1 above, for review by CenCal Health's Health Services Department.
- 11.2.2 On or before the Member's last covered day, Hospital's UR staff will prepare an 18-1 Form and will furnish this 18-1 Form and all pertinent medical information to the UMC at the UMC's next scheduled weekly onsite review, or as specified in § 12.3 below for Hospitals outside the service area.
- 11.2.3 After the medical information has been provided to the UMC, the UMC will approve, defer for further information, or recommend denial of further hospital stay to the Medical Director.
- 11.2.4 Recommended UMC denials will be subject to the review and approval or disapproval of the Medical Director. All inpatient days of service provided to a Member shall be considered to be authorized and reimbursable through and including the day ending at 11:59 p.m. of the last day authorized.
- 11.2.5 A provider who disagrees with the decision of the Medical Director may appeal this decision in the manner set forth in the "Procedure for Appeal of Medical Director's Decision", at Section 15 of this Case Management Protocols document.

12 ACUTE CARE HOSPITAL REVIEW PROCEDURES

12.1 Hospital Requirements.

- 12.1.1 Hospital shall identify one of its employees to act as a contact person and shall furnish the UMC with a work area and telephone space, preferably in the area where the contact person is located.
- 12.1.2 The contact person is responsible for submitting medical information to the UMC at scheduled weekly onsite reviews, or if Hospital is out of the service area via mail or electronic transmission.
- 12.1.3 The contact person shall make copies of CenCal Health approved forms available to the UMC upon UMC request.

- 12.1.4 The contact person is responsible for keeping Hospital administration and the attending physician(s) apprised of extension of stay determinations.
- 12.2 Onsite Review Procedures within Santa Barbara County.
 - 12.2.1 CenCal Health's UMC shall travel to Hospital to review and make recommendations regarding requests for extensions of stay beyond the initial length of stay authorized for hospital admissions.
 - 12.2.2 The UMC reports to the designated work area in Hospital and meets with Hospital contact person. A schedule of onsite reviews is coordinated with the contact person.
 - 12.2.3 The Member's medical record may be reviewed by the UMC when deemed necessary by the UMC. Such review shall take place at a location determined appropriate for review by the contact person.
 - 12.2.4 One approval form shall be used for each acute inpatient stay.
 - 12.2.5 The UMC shall refer recommended denials to the Medical Director. In these cases the UMC shall copy all or part of the medical record, as needed for determination, for off-site review by the Medical Director.
 - 12.2.6 The UMC shall inform Hospital contact person in writing of the UMC's extension of stay recommendation and the reason for said recommendation.
 - 12.2.7 The UMC shall document a UMC recommendation for transfer of a Member to a different level of care on the approved form.
 - 12.2.8 The Hospital contact person shall inform the attending physician of the UMC's recommendation. The attending physician may subsequently contact the Medical Director to discuss the UMC's recommendation. The Medical Director evaluates all available information and may request additional information from the attending physician prior to making a decision with respect to the validity of a request for an extension of a hospital stay.
 - 12.2.9 The UMC shall complete the required forms.
- 12.3 Non-onsite Acute Hospital Review Process.
 - 12.3.1 Hospital located outside Santa Barbara County shall contact CenCal Health's UM staff by phone when Member is admitted to Hospital.
 - 12.3.2 After Member is discharged, Hospital shall send the Member's medical record with completed inpatient authorization form to:

CenCal Health UM, 4050 Calle Real, Santa Barbara, CA,
93110.

- 12.3.3 Hospital will be notified of CenCal Health's determination by facsimile.

13 CRITERIA FOR AUTHORIZATION OF ACUTE ADMINISTRATIVE DAYS

- 13.1 Definition. Acute administrative days are those days approved in an acute care inpatient facility which provides a higher level of care than the facility care currently needed by the Member (i.e., licensed nursing facility care).

13.2 Procedures for Authorization of Acute Administrative Days.

- 13.2.1 The necessary documentation shall be presented to the UMC for review at the first onsite visit following the change in the Member's condition, making licensed nursing facility care appropriate, rather than acute level of care.
- 13.2.2 Hospital UR staff will prepare any required forms, including all pertinent medical information.
- 13.2.3 Documentation of placement efforts, in accordance with Section 13.3 below shall be submitted along with the required forms.
- 13.2.4 After review of the required forms, pertinent medical information, and documented placement efforts, the UMC will approve or defer for further information or will recommend denial of acute administrative days to the Medical Director.
- 13.2.5 Recommended denials of acute administrative days are subject to the approval of the Medical Director.
- 13.2.6 A provider who disagrees with the decision of the Medical Director may appeal the decision in the manner set forth in the "Procedure for Appeal of Medical Director's Decision", at Section 15 of these Protocols.

13.3 Required Placement Efforts. Acute administrative days may be authorized subject to the following:

- 13.3.1 Hospital shall make five (5) calls per day for the first five (5) working days, to prospective placement facilities within a sixty (60) minute drive of the Member's place of residence, or further at the Member's request or agreement. After the first five (5) working days, Hospital shall make at least two (2) calls per day for an additional twenty (20) days.
- 13.3.2 The calls being made under Subsection 13.3.1 above can cover any number of Members being placed provided that there is

documentation in the record that each Member was discussed as a placement possibility.

- 13.3.3 Administrative days shall only be authorized on a day during which the required number of calls have been completed under Subsection 13.3.1 above and provided all other review requirements have been met.

- 14 PROCEDURES FOR OUTPATIENT SERVICE AUTHORIZATION
RAFs. All outpatient services for case-managed Members shall require prior authorization from the Primary Care Physician or attending physician.
- 15 PROCEDURE FOR APPEAL OF MEDICAL DIRECTOR'S DECISION
Hospital and/or the Member's physician may appeal a utilization review decision of the Medical Director pursuant to the provider appeals and grievance process policy, which is contained in CenCal Health's Provider Manual.
- 16 MODIFICATIONS OF UTILIZATION MANAGEMENT PROTOCOLS
CenCal Health may modify this Utilization Management Protocols as needed. CenCal Health shall provide Hospital thirty (30) days prior written notice of any proposed modifications to the Protocols, unless changes are required due to regulatory changes. Hospital may subsequently choose to accept the proposed modifications or may choose to terminate its Agreement with CenCal Health.