Part I Section 4

Referrals and Authorizations: UM Department

PRIMARY CARE PHYSICIAN REFERRAL PROCESS

Members of contracted health plans are required to select a PCP from the CCHCA PCP panel. All PCPs are in-network of the Chinese Community Health Care Association (CCHCA) medical group. Family patient members may select different PCP. The PCP is responsible for:

1. Assuring reasonable access and availability to primary care services,
2. Making referrals to specialists and other plan providers,
3. Providing 24 hour coverage for advice and access to care, and
4. Communicating authorization decisions to the health plan member.

Patients may require services that go beyond the scope of their PCP. When this occurs, the PCP refers the member to an appropriate CCHCA in-network specialist using the Specialty Consultation Referral Form.

In the event the CCHCA medical group does not have a needed provider or consultant, the member's PCP or specialist must request prior authorization from the Utilization Management Department to use an out-of-network specialist.

Referrals to In-Network Specialists

The Specialty Consultation Referral Process enables a PCP to coordinate the process by which their patients receive care from CCHCA specialist physicians, behavioral health specialists and other health care providers.

When a CCHCA PCP identifies the need for a referral, the PCP may refer patients to CCHCA specialist physicians, including behavioral health specialists as medically appropriate by completing a CCHCA Consultation Referral Form.

With PCP concurrence, for those services not requiring prior authorization, a CCHCA specialist physician may refer to another CCHCA specialist as medically appropriate by completing a CCHCA Consultation Referral Form.

- A referral is good for 4 visits in a calendar year for the **same diagnosis** to the same specialist. Referrals submitted in December are also valid for the following year up to a maximum of four visits.
- CCHCA specialist visits for a different diagnosis require a new and separate Consultation Referral Form from the PCP with the specific diagnosis.
- Additional visits beyond 4 for the same diagnosis range require prior authorization.
- Services exceeding $500 (of Medicare allowable) require prior authorization.
- If a patient self-refers to a CCHCA OB/GYN specialist for women's health services a referral is not required. For self referred services, the OB/GYN must complete a CCHCA Direct Access Report Form. One copy is submitted to the PCP and another copy is

attached to a paper claim. For electronic claims, CCHCA will audit medical records to verify that the Report Form is in the PCP's file.

- **The Consultation Referral Form cannot be used for non-CCHCA physicians or non-CCHCA behavioral health specialists. All services from non-CCHCA physicians and non-CCHCA behavioral health specialists require prior authorization from the Utilization Management Department.**

Referrals to Out-Of-Network Specialists

Prior authorization is required to refer members to out-of-network specialists.

Consultation Referral Forms

The Consultation Referral Form is to be used for referring patients to in-network CCHCA physicians and in-network behavioral health specialists only. It cannot be used for referring to out-of-network physicians or behavioral health specialists, nor can it be used to request for services that require prior authorizations; (for these services, the Service Authorization Form must be used).

A sample CCHCA Consultation Referral Form is included in the Forms Section of this handbook.

Consultation Referral Procedure

To refer a patient to a CCHCA specialist physician or CCHCA behavioral health specialist:

1. Complete a CCHCA Consultation Referral Form.

   The PCP or referring physician should complete all pertinent information on the top half of the Consultation Referral Form, including the reason for consultation. If the referring physician is not the PCP, the referring physician should obtain consent from the PCP and check mark the box "If referring MD is not the PCP, has PCP consent". The referring physician shall keep the white copy for his/her records.

2. After completing the Referral Form, the referring physician should keep the white copy for his/her records and give the remaining copies to the patient who should be told to bring the Referral form to the CCHCA specialist physician (consultant).

3. **Following consultation, the specialist will fill out the bottom half of the Consultation Referral Form and send a copy of the form/report to the referring physician and PCP**. Consulting physicians and behavioral health specialists must send a written communication to the referring physician.

4. The specialist physician shall keep a copy of the Form for his/her records.

5. For electronic claims, the CCHCA specialist physician or behavioral health specialists (consultant) must indicate the name of the referring CCHCA physician on the electronic claim. For paper claims, the specialist (consultant) physician or behavioral health specialists must submit a copy of the CCHCA Referral Form with the claim.

6. If the specialist physician determines the patient needs a procedure that is an office procedure and the procedure does not require prior authorization, the treating specialist may perform the procedure after consultation with the PCP.

7. If the procedure requires authorization then the specialist must request prior authorization from the Utilization Management Department by completing and submitting a Service Authorization Form (SAF) by fax. If the request is urgent, mark "URGENT" at the top of the SAF.

For a description of "Services Requiring Prior Authorization," See Page 4.

Continuity of Care by a Specialist
(For more than 4 visits in a Calendar Year)

The specialist, in consultation with the PCP, may need to see a patient beyond the PCP's referral (**valid for 4 office visits per calendar year for the same diagnosis**; prior approval is required for further visits). The specialist is required to submit a Service Authorization Form (SAF) to the Utilization Management Department to request additional office visits. The SAF must include the diagnosis, medical justification for additional visits, and treatment plan (i.e., frequency and duration of visits). **The boxes on the top of the SAF "services provided by" and "has PCP approval" MUST also be filled out**.

Standing Referrals to Specialists

It is the policy of CCHCA that a member who requires specialized care over a prolonged period for a life-threatening, degenerative or disabling condition, including human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) may be allowed a standing referral to a specialist who has expertise in treating the condition or disease for the purpose of having the specialist coordinate the member's health care. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, a referral must be made to an HIV/AIDS specialist who meets California Health and Safety Code criteria.

The PCP, specialist and CCHP/CCHCA Medical Director determines that continuing care from a specialist is needed and referrals are made based on an agreed upon treatment plan, if any.

Treatment plans may limit the number of specialist visits or the length of time the visits are authorized and may require the specialist to make regular reports to the PCP.

After the four visits, prior authorization must be obtained. The PCP or specialist must submit a service authorization request form (SAF) for on-going care by the specialist. After receiving standing referral approval, the specialist is authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the PCP. The PCP may refer to an out-of-network specialist if one is not available within the CCHCA medical group who can provide appropriate specialty care to the member.

The standard of 48 hours to make a decision may be extended to five business days because of the requirement to develop a treatment plan. Notification to the patient member must be done by the physician's office within four business days after receipt of request.

OB-GYN Direct Access

In accordance with California law, patients may access CCHCA Ob-Gyn specialists for women's health services without a referral from the PCP.

PRIOR AUTHORIZATION

Prior Authorization is intended to ensure that the requested service is covered by the member's benefit, that the provider of the service is in-network, and that the services are medically necessary. Services will also be reviewed to ensure that the most appropriate setting is being utilized and to identify those members who may benefit from our case management programs. Prior Authorization is subject to a member's eligibility and covered benefits at the time of service.

Utilization Management Department

The Utilization Management Department is responsible for the prior authorization process which includes monitoring inpatient hospitalizations and patients in skilled nursing facilities as well as working with physicians for those patients in need of case management services. Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. No financial incentives are involved in utilization management decisions.

CCHCA uses evidence-based clinical guidelines developed by Milliman Care Guidelines, LLC. The Care Guidelines identify benchmark patient care and recovery stages to enhance health care services delivery, resource management and patient outcomes. This approach can reduce unnecessary variation in health care delivery and health care disparities in our community. The Care Guidelines provide health care professionals with evidence-based clinical guidelines at the point of care. They also support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives. Please contact the UM Department at (415)955-8800 ext. 3286.

SERVICES REQUIRING PRIOR AUTHORIZATION

The CCHCA PCP or specialist physician is required to obtain prior authorization using the Service Authorization Form for the following:

1. All services from out-of-network physicians and providers.
2. Ambulatory surgery
3. Elective hospitalization
4. Skilled Nursing Facilities (SNF)
5. Acute Rehabilitation Facilities
6. Home care services
7. **Outpatient Procedures and Services listed in Section 5 under Category A+B Services as indicated.**

For an alphabetical list of outpatient procedures and services that require prior authorization See Section 5.

Service Authorization Forms (SAF)

A sample CCHCA Service Authorization Form (SAF) is included in the Forms Section of this handbook.

The CCHCA Service Authorization Form (SAF) is used to request prior authorization from the Utilization Management Department. If the SAF is being submitted by a CCHCA referral specialist, he/she may submit an SAF after approval from the PCP.

How to Request Prior Authorization

To request prior authorization:

1. Complete a CCHCA Service Authorization Form (SAF). **Be sure to include**:
   a) The diagnosis and treatment plan,
   b) CPT and ICD-10 Codes, and
   c) **Adequate clinical information which supports the medical necessity of the services requested. Requests for services that do not meet Milliman Care Guidelines and requests submitted without adequate clinical information may be denied or returned for additional clinical information**.

   - Please allow up to 5 calendar days to process authorization requests for routine, non-urgent services.
   - For urgent services, please write "URGENT" at the top of the SAF for priority processing.

2. **Fax** the Service Authorization Form **and** supporting clinical information to the UM Department at **415-398-3669**.
3. Once a determination is made you will receive an approval (or denial) notice via fax. You can also view authorized services at **www.cchphealthplan.com/eligibility_inquiry.**

   - **When services are approved**, the reference number is written on the SAF and it is returned by fax to the requesting physician, the PCP and the provider of the service.
   - **When services are denied**, a denial letter is faxed to the requesting provider and the PCP.

4. After rendering the service be sure the claim includes:
   a) The procedure code(s) that was authorized on the SAF matches the code on the claim form,
   b) The reference number for the authorization,
   c) And, when submitting a paper claim, attach a copy of the SAF.

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Retroactive Authorizations

For services requiring authorization, the request must be submitted prior to rendering the service, to:

1) verify medical necessity,
2) verify the service requested is a covered benefit,
3) verify member eligibility and enrollment, and
4) verify the provider and location of service is in network.

Requests for retroactive authorizations shall not be approved for any elective and non-emergent services.

NOTE: Claims received for elective and non-emergent services without the required prior authorization by the Utilization Management Department will be denied.

Urgent Authorizations

Urgent requests receive special attention. The UM Department makes every efforts to return authorization determinations quickly. Urgently needed care should never be delayed while awaiting prior authorization. Please do not hesitate to ask to speak directly to the UM Manager if you have concerns that our process is interfering with the care your patient requires.

- During Business Hours: Monday – Friday, 9:00 am to 5:00 pm

Outpatient:

If a situation is urgent, submit an SAF marked "URGENT" at the top and it will be given priority processing.

Inpatient:

If there is an urgent need for an inpatient authorization, call the UM Manager at 415-955-8800 ext. 3291.

- Weekends, After Hours, Holidays

On weekends, after hours or holidays, the PCP or the CCHCA attending physician has the authority to authorize treatment for services that the physician considers urgent/emergent. The attending physician should then submit a timely SAF to the Utilization Management Department the next business day.

DISCHARGE PLANNING

Discharge planning to appropriate settings begins on "day one" of a patient's hospital admission. Be sure you are using correct terminology when considering discharge options to appropriate settings. When recommending Skilled Nursing Facilities for patients, they need to meet Milliman clinical criteria. Patients who need acute rehabilitation care, hospice care or long term care, or patients who do not want to go home due to social issues, should not be placed in Skilled Nursing Facilities. In particular:

Skilled Nursing Facility (SNF) – Placing patients in an SNF requires prior authorization from the UM Department to determine whether the patient meets criteria for skilled nursing. The UM Department will also confirm that the SNF is a contracted provider and verify the patient's SNF benefits.

Skilled nursing benefits shall be provided to a patient requiring skilled nursing services on a daily basis and/or skilled rehabilitation services at least 5 days per week. Skilled nursing or skilled rehabilitation services must be ordered by a physician and performed by or under the supervision of a licensed nurse, physical therapist, occupational therapist, or speech therapist. Examples of skilled nursing services on a daily basis include:

- Administration of enteral feedings, intravenous medications, extensive pressure ulcer care, nasopharyngeal and tracheostomy suctioning.
- Teaching and training by skilled personnel with the goal of promoting independence (For example, teaching self-administration of injectable medications or colostomy care).

Long Term Care Facility (LTCF) – Patients who do not meet criteria for skilled nursing facility care but who need 24 hour assistance should be placed in Long Term Care Facilities. However, Long Term Care is not a benefit of CCHCA contracted health plans, and therefore, does not require prior authorization. Most hospital discharge planners can assist with finding Long Term Care Facilities.

Custodial care is excluded from coverage. Personal care services that do not require the skills of qualified technical or professional personnel are not skilled services. Custodial care services involve the assistance of an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. In determining whether a person is receiving custodial care, the factors considered are the level of care and medical supervision required and furnished.

Acute Rehabilitation Facility – Placing patients in an Acute Rehab Facility requires prior authorization and must meet Milliman criteria. It is for patients who have experienced a major injury, disorder or illness who are in need an intensive inpatient program to regain the skills needed to retrain a person on the basics of activities of daily living or achieve

baseline level of functioning. Skilled rehabilitation services include providing therapy for a patient with the goal of measurable functional improvement in a reasonable period of time.

Hospice Care – Hospice benefits are limited and therefore, require prior authorization so that the patient receives the care provided in their evidence of coverage.

Nurse Reviewers Support Physicians in Discharge Planning

The UM Department's Nurse Reviewers are available to assist physicians in planning for discharge and the post acute hospital phase. During the treatment planning phase, options for post acute services should be identified early in the enrollees' hospitalization. If your patient is hospitalized at a contracted hospital, the Nurse Reviewer can work with their staff to transfer the patient to Chinese Hospital when appropriate. If the patient discharge is from another facility, the Case Manager coordinates with the hospital staff to assure a smooth transition out of the acute care facility.

The Nurse Reviewer can assist you by:

- Working with you to identify services that can benefit the patient after acute hospitalization.
- Contacting Clinical Social Workers to arrange for Skilled Nursing Facility placement or Home Health Care.

Summary of CCHCA Authorization Procedures

TYPE	AUTHORIZATION PROCEDURE
Elective admission - Scheduled more than 5 days ahead	FAX Service Authorization Form (SAF) with clinical information to the UM Department for pre-authorization.
Urgent care necessary. Authorization can be obtained, **but not emergent.** **9:00 am-5:00 pm (Mon-Fri)** **After Hours/ Weekends/Holidays**	- Fax Service Authorization Form marked "URGENT" to 415-398-3669 for an expedited authorization. - Treat as an emergency. PCP or attending physician may authorize treatment for urgent/emergent services. A retroactive Service Authorization Form must be submitted by FAX by the attending physician on the next business day.
Emergency admission at Chinese Hospital	No authorization necessary.
Emergency admission **NOT** at Chinese Hospital	Notify UM Department on the same or next business day.
Ambulatory Surgery	FAX a Service Authorization Form with clinical information to the UM Department for a pre-authorization.
Referral from PCP to CCHCA Consultant: 1) Initial 4 visits per calendar year **for same diagnosis**. 2) Greater than 4 referral visits	1) No authorization from the UM Department necessary for the first 4 visits for same diagnosis in a calendar year. Visits for a different diagnosis requires new referral (Form) from PCP. 2) PCP or Consultant submits Service Authorization Form to the UM Department for an authorization for additional visits.
Referrals to non-Plan Providers	Prior authorization required. FAX Service Authorization Form with clinical information including why service not available in-network, to the UM Department.
Lab and X-ray services (except for asterisked procedures listed in Category A and Category B in Section 5.	No authorization from the UM Department necessary if preferred facilities are used. SAF must be submitted for non-plan facilities and asterisked Category A and Category B services.
Category A procedures (Asterisked procedures) Category B procedures (Asterisked procedures)	Prior authorization required from UM Department for asterisked procedures. Fax SAF with clinical information to UM Dept.
-Transfer to/from other facilities - Home Care, PT. OT. DME, Speech Therapy	Prior authorization required. FAX Service Authorization Form to the UM Department. Provide Certificate of Medical Necessity where appropriate.

Utilization Management Department FAX Number: 415-398-3669