Section 4 – Utilization Management

Utilization Management Overview

The Utilization Management (UM) Program is designed to monitor, evaluate, and manage the appropriateness of care resources, promote the delivery of high quality, medically necessary and efficient care.

The UM Department is responsible for the prior authorization process. The UM Department ensures services delivered are medically necessary based on evidence-based criteria and the level of care need for a member.

UM policies and procedures are available upon request. Please contact the UM Department at (415) 216-0088.

Decision Making

Utilization Management (UM) decision making is based only on the appropriateness of care and service and existence of coverage. Chinese Community Health Care Association (CCHCA) does not specifically reward practitioners or other individuals for issuing denials of coverage or care. No financial incentives are involved in UM decisions that result in underutilization.

Criteria

CCHCA uses evidence-based clinical guidelines to include but not limited to:

- California Department of Health Services (DHCS) Medi-Cal criteria
- Health Plan criteria
- MCG®
- Internally developed criteria and/or policies
- Specialty guidelines, as published by individual specialty organizations as well as government agencies including but not limited to National Comprehensive Cancer Network (NCCN), AIM guidelines, World Professional Association for Transgender Health (WPATH), etc.

In some cases, the Medical Director may need to consult with a board-certified physician to assist in the medical necessity determination process.

To request a copy of the criteria utilized to make a denied determination, please contact the UM Department at (415) 216-0088. Criteria is available upon request.

Prior Authorization

Prior authorization is intended to ensure that the requested service(s) is a covered benefit by the member's Health Plan, that the requested provider is in-network and contracted, and that the service(s) 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.

The CCHCA Authorization Request Form (ARF) is used to request prior authorization from the Utilization Management Department. The ARF can be found on the CCHCA website (https://www.cchca.com.)

How to Request Prior Authorization

Complete a CCHCA Authorization Request Form (ARF). Be sure to completely fill out the ARF, if information is missing it may delay the decision. Areas to be completed include but is not limited to:

a) Indicate if the request is a routine, retro or urgent by checking the appropriate box on the top portion of the ARF. An urgent request is when the normal timeframe for authorization could seriously jeopardize the life, health and safety of the member or others, due to the member's psychological state or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
b) Requesting/Current Provider – This is the name of the requesting/referring from provider.
c) Provider/Vendor Request for Service – This is who will provide/render the service(s). Indicate the referring to provider's name, not the group or facility the provider is affiliated with.
d) Facility – If requesting a surgery or procedure, document the facility name where the service(s) will be rendered.
e) ICD-10 & Diagnosis – CCHCA UM staff cannot apply the ICD-10 code(s), this is required to be completed by the provider office.
f) Service (CPT or HCPC) – CCHCA UM staff cannot apply the CPT or HCPC code(s), this is required to be completed by the provider office. Ensure you verify that codes are not submitted unbundled, as this may cause a denial or modification of services.
g) Adequate clinical information which supports the medical necessity of the service(s) requested. Include recent progress notes and other supporting

documents to include but not limited to, lab results, radiology reports, pathology reports, previous colonoscopy and/or EGD report and pathology report, previous biopsy results, mammogram results and previous Dexa Scan result/report. Requests for services that do not meet the appropriate criteria applied may be denied. Requests without adequate clinical information may be pended causing a delay in making a decision.

Fax routine and retro requests **and** supporting clinical information to the UM Department at **(888)744-8665**.

Fax urgent requests **and** supporting clinical information to the UM Department at **(833) 964-0916.**

Once an approval or denial determination is made you will receive notice via fax. The letter will include the reference number. You can also view authorized services through CCHCA's Provider Portal (https://providerportal.cchca.com/EZ-NET60/Login.aspx).

When services are denied, a denial letter is faxed to the requesting from provider and the PCP. If you don't agree with the denied determination, you can phone the UM Department at (415) 874-4431 or send an email to peer-to-peer@cchca.com and request a peer-to-peer review with the Medical Director. Provider requests for a peer-to-peer review must be within 30 days from the date of the denied determination.

Turn Around Time Decision Standards

Routine/Non Urgent Requests	Up to 5 business days
Urgent Requests	Up to 72 hours
Retro Requests	Up to 30 calendar days

Urgent Authorizations

The UM Department makes every effort to process an urgent request in a timely manner appropriate for the member's condition not to exceed 72 hours from the receipt of request. Please do not hesitate to ask to speak directly to UM Management if you have concerns that our process is interfering with the care your patient requires.

Normal Business Hours: Monday – Friday, 8:30 AM to 5:00 PM

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 CCHCA panel of physicians. 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 can refer the member to an appropriate CCHCA in-network specialist.

In the event the CCHCA 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 Out-Of-Network Specialists

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

Consultation Referral Procedure

To refer a patient to an in-network contracted CCHCA specialist physician or in-network CCHCA behavioral health specialist:

1. The PCP can verbally refer the patient to an in-network CCHCA specialist physician or in-network behavioral health specialist without prior authorization.

2. The PCP office will contact the in-network CCHCA specialist physician or in-network behavioral health specialist office to inform them about the referral of a patient and send the clinical notes to the CCHCA specialist physician or behavioral health specialist once an initial office visit has been confirmed.

3. Consulting physicians and behavioral health specialists must send a consultation report to the referring physician.

4. 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.

5. If the procedure requires prior authorization, the treating specialist must request prior authorization from the Utilization Management Department via the Provider Portal or complete and submit the Authorization Request Form (ARF) by fax. If you don't have access to the Provider Portal contact the CCHCA Provider Relations Department at (415) 216-0088.

Retrospective Authorizations

The Utilization Management (UM) Department reviews retrospective authorization requests.

A provider must submit a request for a retrospective review to the UM Department within ninety (90) calendar days from the date of service.

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 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.

Physicians can request for a standing referral to a specialist by using the Authorization Request Form (ARF) and indicating standing referral request. The PCP or specialist must submit an ARF for on-going care by the specialist. After receiving a 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.

A decision will be made within 3 business days of the day of receipt of the request and all appropriate medical records are received. Notification of the approval will be made within four business days after receipt of request.

OB-GYN Direct Access

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

Sterilization Requirement

Education about sterilization services is available to providers during the new contract orientation. Providers are required to complete the correct PM 330 Consent Form for Sterilization as required by law, prior to rendering a sterilization procedure to Medi-Cal patients.

Sterilization requirements:

1. The member is at least 21 years of age at the time the consent is obtained.
2. The member Is not mentally incompetent.
3. The member Is able to understand the content and nature of the informed consent process
4. The member Is not institutionalized and has signed and dated the consent form.

The sterilization procedure must be completed at least 30 days but no more than 180 days after the date in which informed consent was obtained except in the following cases:

1. Involving an emergency abdominal surgery.
2. Premature delivery in which specific requirements are met.
3. At least 72 hours have passed after written consent was given and the performance of the emergency surgery.

Providers are required to educate the member regarding the sterilization procedure and provide the member with the DHCS Booklet on Sterilization. The conversation and notation of providing the booklet is required to be noted in the member's medical record.

Upon receipt of a request for sterilization, UM staff will ensure a copy of the PM 330 is received and completed. The PM 330 is required to be submitted along with the sterilization claim.

The PM 330 consent form along with how to complete it, can be found on the Medi-Cal website https://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_Eng-SP.pdf .

The booklet can be found on the DHCS website at: https://www.dhcs.ca.gov/Pages/permanentbirthcontrol.aspx

Services Requiring Prior Authorization

Category A – Services that may be performed in an office setting. Offices performing these services should have an appropriate CLIA license for CLIA waived services. Category A services are further divided into Categories A1, and A2:

- **Category A1** – Services may be performed in an office setting by the PCP or the contracted in-network specialist physician as part of the diagnostic evaluation and treatment.
- **Category A2** – Services may be performed in an office setting only by a contracted in-network specialist.

Category B – Services must be performed only in an authorized in-network contracted facility or obtained from a contracted in-network provider.

Certain Category A and B services (as indicated with "Yes") require prior authorization by the Utilization Management Department.

** Category marked with "X" is the **preferred** method for the services/procedures. **

List of Category A and B Services

Services/Procedures	Prior Authorization Required?	Category A1	Category A2	Category B
		May be Performed in a PCP or an In-Network Contracted Specialist Office	**May be Performed only in an In-network Contracted Specialist Office or an In-network Contracted Facility**	**Must be Performed in an In-network Contracted Facility or From an In-Network Provider**

Referrals to out-of-network providers/facilities	Yes	N/A	N/A	N/A
Second Opinions	Yes	X		
All procedures or services not listed below that are provided outside of a PCP or Specialist office, and require to be done in a medical facility	Yes			X
Acupuncture	Yes		X	
Allergy (skin tests)	No		X	
Amniocentesis	No		X	
Anoscopy	No	X		
Barium Enema Contrast Study	Yes			X
Bone Density Scan (initial and subsequent scans) (refer to the below for an auto approval)	Yes			X
CAT Scan	Yes			X
CLIA Waived Tests	No	X		
Colonoscopy	Yes			X
Colposcopy	No		X	
Cystoscopy	No		X	
Dialysis (refer to the below for an auto approval)	Yes			X
Durable Medical Equipment (any) (refer to the below for an auto approval)	Yes			X
Echocardiogram	Yes		X	
EEG, EMG or ENG	Yes		X	
Electrocardiograms (EKG)	No	X		
Endoscopy/Upper Endoscopy	Yes		X	
Epidural Blocks (pain management)	Yes		X	
Fetal Testing, Stress & Non-stress	No		X	X
Fine Needle Aspiration	No	X		
Fundus, Extended Exams	No		X	
Gallbladder Contrast Study	Yes			X
Glaucoma Provocation Test	No		X	
Gonioscopy	No		X	
Heart Scans	Yes			X
Holter Monitor	No		X	

Home Health Services	Yes			X
Immunizations/Vaccines (non- travel)	No (except for the below)	X		
Immunizations/Vaccines (travel)	Yes	X		
Liver/Spleen Study	Yes			X
Lung Study	Yes			X
Mammogram (screening) (refer to the below for an auto approval)	No			X
Mammogram (diagnostic)	Yes			X
Medical Macrophotography	No		X	
MRI Scan	Yes			X
Nuclear Cardiograms	Yes			X
Occupational Therapy	Yes			X
Ophthalmologic Tests	No		X	
PET Scan	Yes			X
Physical Therapy	Yes			X
Proctosigmoidoscopies	No	X		
Pulmonary Function Test	No		X	
Small Bowel Series Contrast Study	Yes			X
Screening Audiometry	No	X		
Sigmoidoscopies	No		X	
Skin Tests (except allergy testing)	No	X		
Speech Therapy	Yes			X
Stress Testing	No		X	
Thallium Stress Test	Yes			X
Thyroid scans	Yes			X
Tonometry (1/year screen by non-specialist)	No	X		
Transplant Services	Yes		X	X
UGI Contrast Study	Yes			X
Ultrasound (pregnancy – 1st & 2nd)	No		X	
Ultrasound (pregnancy – subsequent after 2nd)	Yes		X	
Ultrasound (non-OB)	Yes			X
X-Rays Plain View and Plain Film (diagnosis & treatment)	No	X	X (Orthopedic Provider Only)	X

Immunizations/Vaccines Requiring Prior Authorization	• HPV Human Papillomavirus Vaccination • Zoster

All procedures being performed in an outpatient setting regardless of the facility (Hospital or Ambulatory Surgery Center) requires prior authorization to a contracted in-network facility.

Auto Approved Services

Durable Medical Equipment – Cane

Health Plan/Line of Business	CPT Code(s)	Place of Service	In-Network Rendering Providers/Vendor
SFHP	E0100 (single point cane) E0105 (quad cane)	12 Home	Apria Healthcare Byram Healthcare California Home Medical Equipment (CHME) Freedom Mobility Hygeia II Medical Group Sincere Care Sunrise Medical Supplies

Durable Medical Equipment – Walker

Health Plan/Line of Business	CPT Code(s)	Place of Service	In-Network Rendering Providers/Vendor
SFHP	E0135 (walker folding pickup) E0143 (walker folding wheeled) E0141 (walker rigid wheeled) E0130 (walker rigid pickup) E0156 (walker w/ seat)	12 Home	Apria Healthcare Byram Healthcare California Home Medical Equipment (CHME) Freedom Mobility Hygeia II Medical Group Sincere Care Sunrise Medical Supplies

Colonoscopy

Health Plan/Line of Business	CPT Code(s)	Place of Service	In-Network Rendering Providers/Vendor
SFHP	45378 (w/ collection of specimen and/or 45280 (w/ biopsy) G0121 (M/C screening not high risk) G0105 (M/C screening high risk) G0104 (M/C screening w/ flex sig)	24 ASC	Campus Surgery Center Digestive Diagnostic Center Golden Gate Endoscopy Center Peninsula Endoscopy Center Presidio Surgery Center San Francisco Surgery Center

Dexa Scan

Health Plan/Line of Business	CPT Code(s)	Place of Service	In-Network Rendering Providers/Vendor
SFHP	77080 (1 or more sites skeleton; hip, pelvis, spine) 77081 (1 or more sites skeleton; wrist, radius, heel, etc)	11 Office	Golden Gate Radiology Medical Group Health Diagnostics/SimonMed Peninsula Diagnostic Imaging

Mammography

Health Plan/Line of Business	CPT Code(s)	Place of Service	In-Network Rendering Providers/Vendor
SFHP	77067 (screening – bilateral) 77066 (diagnostic – bilateral) 77065 (diagnostic – unilateral) 77063 (screening 3D – bilateral) 77062 (diagnostic 3D – bilateral)	11 Office	Golden Gate Radiology Medical Group Health Diagnostics/SimonMed Peninsula Diagnostic Imaging

Dialysis

Health Plan/Line of Business	CPT Code(s)	Place of Service	ICD10 Code	In-Network Rendering Providers/Vendor
SFHP	90999	11 Office or 65 ESRD Treatment Facility	N18.6 ESRD	Davita, Satellite Dialysis

Procedures Recommended to be Performed in an Outpatient Setting

The following procedures are recommended to be performed in an outpatient ambulatory surgery setting. This is not an exclusive list of procedures. Exceptions require prior authorization.

A. <u>Gastroenterology</u>
- Liver Biopsy
- Colonoscopy (screening)
- ERCP (Endoscopic Retrograde Cholangia Pancreatology)
- Sigmoidoscopy
- Esophagogastroduodenoscopy (EGD)
- Esophagoscopy

B. <u>Gynecology</u>
- Marsupialization of Bartholin Cyst

- Treatment of Condylomata Acuminata
- Cryotherapy (alone or with a biopsy and/or dilation & curettage)
- Dilation and Curettage
- Examination under Anesthesia
- Culdoscopy
- Hymenotomy
- Hysterosalpingogram
- Therapeutic Abortion (first trimester)
- Dilation and Evacuation (second trimester)
- Laparoscopy, diagnostic, or sterilization
- Removal of IUD
- Hysteroscopy
- Culdocentesis (office)
- Amniocentesis or Amniogram
- Perinerrhaphy (minor)
- Cervical Amputation
- Cervical Conization

C. General Surgery

- Breast Biopsy (if a two-stage procedure for a possible malignancy)
- Cervical Node Biopsy
- Lipoma Excision
- Muscle Biopsy
- Rectal Polypectomy
- Excision of Sebaceous Cyst
- Excision of Skin Lesion with Primary Closure
- Excision Bakers cyst
- Excision Breast Masse(s)
- Excision Draining Sinus Tract
- Excision Neuroma
- Foreign Body Removal
- I & D abscesses
- Varicose Vein Ligation (without stripping)
- Minor hemorrhoidectomy
- Hernia Repair (infant)
- Paracentesis

D. Plastic Surgery

- Blepharoplasty (upper/lower or combined)

- Mammoplasty (augmentation, revision) after mastectomy for cancer, unless major case requiring postoperative hospital days.
- Small Skin Graft
- Dupuytren's Contracture
- Many Tendon Repairs
- Fingertip Injury Revisions
- Excision Lesions (minor)
- Excision Ganglion (wrist)
- Acute Nerve Repair (hand)
- Other Minor Hand Procedures
- Staged Reconstructive Procedures
- Scar Revision

E. Ophthalmology

- Argon Laser Prescription
- Chalazion
- Discission
- Ectropion and Entropion
- Insertion of lass tube into lacrimal duct
- Lacrimal Duct probing
- Pterygium
- Strabismus

F. Otolaryngology

- Myringotomy (with or without tubes)
- Antral Puncture (with or without irrigation)
- Inferior Turbinate Fracture
- Nose, Closed Reduction
- Type I: Tympanoplasty with removal of attic and oval window cholesteatoma sacs
- Nasal reconstruction
- Otoplasty unilateral, bilateral (Depending on age: young children may require hospitalization overnight)
- Cervical node biopsy
- Esophagoscopy
- Frenulectomy
- I and D abscess (simple)
- Otoscopy (with or without removal of foreign body)
- Removal foreign body from nose or ear
- Removal scars, moles, or basal cell CA
- Wiring simple joint fracture

G. Orthopedic Surgery
- Ganglion Excision
- Carpal tunnel decompression
- Excision of foreign body
- Tenotomy
- Manipulation of joints, individual consideration, depending upon the joint involved and indication for procedure
- Removal of bursae (Olecranon)
- Dupuytren's Contracture
- Many Tendon Repairs

H. Urology
- Circumcision (pediatric and adult)
- Dorsal slit
- Meatotomy
- Urethra dilation
- Vasectomy
- Cystoscopy
- Fulguration of venereal warts
- Excision and biopsy of scrotal lesion
- Cystoscopy and retrograde
- Prostatic biopsy

I. Endoscopy
- Culdoscopy
- Diagnostic cystoscopy
- Gynecological laparoscopy
- Otoscopy
- Proctosigmoidoscopy
- Fiberoptic sigmoidoscopy and fiber optic colonoscopy (diagnostic only)
- Gastroscopy

J. Thoracic or Vascular
- Esophageal dilation
- Excisional surgery: chest wall lesion
- Lymph node biopsy
- Mediastinoscopy
- Thoracentesis

K. Pulmonology

- Bronchoscopy

Procedures Recommended for Same Day Surgeries

Prior authorization is required from CCHCA

A. Gynecology
- Mini Lap (tubal ligation)
- Bartholin Cystectomy
- Vaginal Tubal Ligation

B. General Surgery
- Pilonidal Cystectomy
- Excision of Thyroglossal Duct Cyst
- Varicose vein ligation with stripping
- Hernia repair (Inguinal and Femoral)
- Umbilical Herniorrhaphy

C. Ophthalmology
- Correction of eye muscle impairment
- Cataract extraction
- Iridectomy
- Phacoemulsificati
- Prolapsed iris, etc.
- Reconstruction of lacrimal duct

D. Urology
- Cystoscopy with fulguration of small bladder tumors
- Instillation of chemotherapy in ureter and bladder locally

E. Otolaryngology
- Ethmoidectomy (intranasal)
- Tonsillectomies
- Adenoidectomies
- T and A
- Tympanoplasty
- Sinus surgery

F. Neurosurgery

- Morton's neuroma
- Neuroma

G. Cardiology
- Pacemaker generator change
- Pacemaker programming
- Cardiac catheterization (if findings negative)

H. Orthopedics/Podiatry
- Morton's neuroma
- Hammertoes with tonotomies and resection of bone (This procedure is recommended for outpatient surgery except when performed on both feet at the same time, or when the patient is elderly and cannot ambulate on crutches or walker without physical therapy training)
- Arthroscopy
- Bunionectomy

I. Endoscopy
- Observation bronchoscopy (flexible, in patient under 40 years of age)
- Triple upper endoscopy

Summary of CCHCA Authorization Procedures

Use the CCHCA Authorization Request (ARF) Form	Fax to: (888) 744-8665 – Routine & Retro Services Fax to: (833) 964-0916 – Urgent Service Electronically through CCHCA's Provider Portal
Laboratory (CCHCA's contracted in-network provider is: LabCorp. Please use the appropriate LabCorp order form)	No authorization is necessary for services to be performed at LabCorp An authorization is required for services to an out-of-network facility. An Authorization Request Form (ARF) can be submitted by: Fax to: (888) 744-8665 – Routine & Retro Services Fax to: (833) 964-0916 – Urgent Service

	Electronically through CCHCA's Provider Portal
Radiology Services	Authorization depends on services requested. An Authorization Request From can be submitted by: Fax to: (888) 744-8665 – Routine & Retro Services Fax to: (833) 964-0916 – Urgent Service Electronically through CCHCA's Provider Portal
Other Services: Home Health Care, Physical Therapy, Occupational Therapy, Durable Medical Equipment, Speech Therapy	Authorization required. Authorization Request Form (ARF) can be submitted by: Fax to: (888) 744-8665 – Routine & Retro Services Fax to: (833) 964-0916 – Urgent Service Electronically through CCHCA's Provider Portal
Ambulatory Surgery	Authorization required. Submit the Authorization Request Form with clinical information and any other supporting documents. Authorization Request Form (ARF) can be submitted by: Paper via Fax to: (888) 744-8665 – Routine Services Paper via Fax to: (833) 964-0916 – Urgent Services Electronically through CCHCA's Provider Portal
Elective Hospital Admission	Authorization required. Submit the Authorization Request From with clinical information and any other supporting documents. Authorization Request Form (ARF) can be submitted by: Paper via Fax to: (888) 744-8665 – Routine & Retro Services Paper via Fax to: (833) 964-0916 – Urgent Services

	Electronically through CCHCA's Provider Portal
Urgent Authorizations	Authorization may be processed in an expedited manner when marked as urgent. An urgent request is when the normal timeframe for authorization could seriously jeopardize the life, health and safety of the member or others, due to the member's psychological state or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
Emergency Hospital Admissions	The hospital is required to notify CCHCA's UM Department within 24 hours of the admit Fax the face sheet to: (833) 964-0922

Utilization Management Department Fax Numbers:

(888)744-8665 – Routine and Retro Services

(833) 964-0916 – Urgent Services

(833) 964-0922 – Acute Admission Face Sheets and Clinical Notes

(833) 964-0918 – SNF Face Sheets and Clinical Notes

Home Oxygen Therapy

Home oxygen requires prior authorization from the Utilization Management (UM) Department ***before*** placing an order with the contracted in-network oxygen vendor.

When requesting an authorization for home oxygen, in addition to the Authorization Request Form, please submit:

1) Documentation of the respective diagnosis
2) A certificate or indication of medical necessity
3) Recent documentation of Arterial Blood Gas (ABG) or oximetry

Procedure of Obstetrical Services

To obtain authorization for pregnancy benefits, the following protocol is to be followed:

1) PCP shall refer patient to OB-GYN specialist/obstetrician for pre-natal care and delivery
2) The obstetrician shall submit an Authorization Request Form (ARF) once a pregnancy has been confirmed. The ARF should include date of last menstrual period (LMP) and an estimated date of confinement (EDC).
3) All obstetrical admissions are subject to concurrent review.
4) Pregnancy Ultrasounds:
    a. An initial ultrasound study in a pregnant patient and one follow-up study does not require an approval from CCHCA's UM Department and may be performed either at in-network radiology facility or in an approved contracted in-network physician office. Subsequent studies may require an approved service authorization with indications of medical necessity for follow-up

Acupuncture Services

The PCP or in-network contracted specialist physician may refer a member for consultation with an acupuncturist.

Authorization from CCHCA is required. Requests must be to an CCHCA in-network contracted acupuncture specialist. The PCP or in-network contracted specialist must submit an Authorization Request Form (ARF) to CCHCA's UM Department for approval.

California Children Services Program

The California Children Services (CCS) program was established in 1927 to assure children with serious medical conditions receive quality health care for their eligible conditions. CCS is a statewide program that provides diagnostic and treatment services, case management and physical and occupational therapy to children under the age of 21. Services provided under the CCS program are authorized and reimbursed by the CCS program. CCHCA or the members Health Plan is not financially responsible.

The member's PCP is responsible for all primary care and other services unrelated to the CCS eligible condition the member need. Until eligibility is established with the CCS

program and services are approved, CCHCA will continue to provide medically necessary covered services.

Eligible conditions include but is not limited to:

- Physical disabilities
- Complex medical conditions such as Sickle Cell Anemia, Cerebral Palsy, Hemophilia
- Cancer
- Diabetes
- HIV
- Complications related to a premature birth

To be eligible for the program, the member must be under the age of 21, have a CCS eligible medical condition, a resident of California and meet the family financial criteria. There is an application process to determine the member meets the program eligibility requirements. The application to determine program eligibility can be found at; https://www.dhcs.ca.gov/services/ccs/Pages/ProviderForms.aspx

In order for CCS to cover services, the child is required to be referred to a CCS paneled provider and receive services at a CCS approved hospital or Special Care Center. A list of these can be found at; https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx

When submitting a request for services to CCS providers are required to use the Client Service Authorization Request (SAR) form. The form can be found at; https://www.dhcs.ca.gov/services/ccs/Pages/ProviderForms.aspx. At the time services are approved or denied, CCS will send an Authorization for Services letter (approval) or a Notice of Action letter (denial) to the PCP or referring from provider.

Eligible children transition out of CCS on their 21st birthday. At this time CCHCA is responsible to ensure continuity of care of all medically necessary covered services.

Comprehensive Perinatal Services Program

The Comprehensive Perinatal Services Program (CPSP) provides services for pregnant women from conception through 60 days postpartum. Services provided include but is not limited to:

- Standards obstetrical services/care
- Nutrition services and education
- Psychosocial services
- Health education
- Prenatal vitamin/mineral supplements

Various providers can offer services; GP, FP, OB/GYN, Pediatrician or Certified Nurse Midwife. The provider is required to be CCS certified. The application for certification can be found at;
https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/Default.aspx

Enrollment in the CPSP program is voluntary, however every Medi-Cal pregnant member must be offered CPSP services. Should a member declines services, the provider is required to have a member sign an acknowledgment form indicating they were offered services and declined.

Child Health and Disability Prevention Program

Child Health and Disability Prevention Program (CHDP) is a preventive program that delivers periodic health assessments to low-income children and youth. CHDP provides care coordination with the member's primary care provider to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

Health assessments can be completed by a physician, the local Health Department, community clinics and some local school districts. Services are required to be provided in accordance with the most current CHDP standards and the current AAP periodicity tables. If the member refuses CHDP service, the provider is required to document this in the member's chart.

CHDP coverage is at no cost to the member ages 0-20.

Early Intervention / Early Start

Early Intervention (EI) or Early Start (ES) services are available to infants and toddlers up to 36 months of age who have a developmental delay, disability or an established risk condition with a high probability of resulting in a delay. Services are provided from the local Regional Center.

Early Start provides various services including but not limited to:

- Occupational and Physical Therapy
- Audiology
- Speech and language services
- Family counseling
- Speech therapy

Palliative Care

Palliative care consists of patient and family centered care to optimize the quality of life by anticipating, preventing, and treating suffering. Receiving palliative care services does not reduce or eliminate other health care services or benefits the member is entitled to and does not affect the member's eligibility.

Palliative care does not require the member to have a life expectancy of 6 months or less and palliative care may be provided concurrently with other treatments.

Members over the age of 21, cannot be enrolled concurrently in palliative care and hospice care. However, a member under the age of 21 can be concurrently enrolled in palliative care and hospice care.

End of Life Services

Terminally ill Medi-Cal members, age 18 or older with the capacity to make medical decisions are permitted to request and receive prescriptions for aid-in-dying medications for certain conditions. The provision of this service by a provider is voluntary and refusal to provide these services will not place the physician at risk for civil, criminal, or professional penalties.

End of life (EOL) services also include a consultation. EOL services are carve out from CCHCA and covered by Medi-Cal FFS. The member is responsible for finding his/her own Medi-Cal FFS physician for all aspects of the benefit. If the member's physician is enrolled as a Medi-Cal FFS provider, he/she may elect to become the members attending physician. If the member's physician is not a Medi-Cal FFS provider, he/she should document the members request and advise the member to select a Medi-Cal FFS provider.

Behavioral Health Treatment (Carve Out Service)

Behavioral Health Treatment (BHT) is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including direct observation, measurement, and functional analysis of the relations between environment and behavior.

BHT services teach skills through the use of behavioral observation and reinforcement or through promoting to teach as step of targeted behavior.

BHT services are designed to be delivered primarily in the home and in other community settings.

In order to be eligible a Medi-Cal member must meet all the following criteria:

- Be under 21 years of age
- Have a recommendation from a licensed physician, surgeon, or a licensed psychologist that services are medically necessary after a diagnosis of autism spectrum disorder (ASD).
- Be medically stable

Be without a need for 24 hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.