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.

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 an in-network 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 in-network specialist physicians, including behavioral health specialists as medically appropriate.

With PCP concurrence, for those services not requiring prior authorization, a CCHCA specialist physician may refer to another CCHCA in-network specialist as medically appropriate.

- **Submit an Authorization Request Form for all services from non-CCHCA physicians and non-CCHCA behavioral health specialists as it requires 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 Procedure

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

1. PCP can verbally refer the patient to an in-network CCHCA specialist physician or in-network behavioral health specialists.

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

3. Consulting physicians and behavioral health specialists must send a written communication to the referring physician.

4. For electronic claims and paper claims, the CCHCA specialist physician or behavioral health specialists (consultant) must indicate the NPI and name of the referring CCHCA physician on the claim.

5. 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.

6. If the procedure requires authorization then the 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 the request is urgent, mark "URGENT" at the top of the ARF. If you don't have access to the Provider Portal contact the CCHCA Provider Relations Department.

For a description of "Services Requiring Prior Authorization," See Page 21.

Continuity of Care by a Specialist

The specialist, in consultation with the PCP, may need to see a patient beyond the PCP's referral. The specialist is required to submit an Authorization Request Form (ARF) to the Utilization Management Department to request additional office visits. The ARF must include the diagnosis, medical justification for additional visits, and treatment plan (i.e., frequency and duration of visits).

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 Standing Referral to a specialist by using the Authorization Request Form (ARF) and indicating standing referral request. After four visits, prior authorization must be obtained. The PCP or specialist must submit a Authorization Request Form (ARF) 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. CCHCA does not specifically reward practitioners or other individuals for issuing denials of coverage or care. No financial incentives are involved in utilization management decisions that result in underutilization

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

- National and Local Coverage Determination (Medicare Determinations)
- California Department of Health Services (DHCS) Medi-Cal criteria
- Health Plan internally developed and approved criteria
- MCG®
- 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.
- CMO or MD review of the evidence in consultation with board-certified consultants that assist in making medical necessity determinations

Milliman Care Guidelines, LLC (MCG). MCG identifies 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. MCG provides 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.

Sterilization Requirement

Education about sterilization services is available to providers during new hire 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. At least 21 years of age at the time the consent is obtained.
2. Is not mentally incompetent.
3. Is able to understand the content and nature of the informed consent process
4. Is not institutionalized and has signed and dated the consent form.

The sterilization procedure must be done at least 30 days but no more than 180 days after the date upon 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 PM330 is required to be submitted along with the sterilization claim.

The PM 330 Consent Form along with how to complete, can be found on the Medi-Cal website http://files.medi-cal.ca.gov/pubsdoco/forms.asp. The booklet can be found on the DHCS website at https://www.dhcs.ca.gov/Pages/permanentbirthcontrol.aspx

To request a copy of the criteria utilized to make request determination, please contact the UM Department at (415) 590-7431. Criteria is available upon request.

UM policies and procedures are available upon request. Please contact the UM Department at (415) 590-7431.

SERVICES REQUIRING PRIOR AUTHORIZATION

The CCHCA PCP or specialist physician is required to obtain prior authorization using the Authorization Request Form (ARF) 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, patient services require authorization as indicated**

Authorization Request Form (ARF)

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

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

How to Request Prior Authorization

To request prior authorization:

1. Complete a CCHCA Authorization Request Form (ARF). **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 business days to process authorization requests for routine, non-urgent services for Medi-Cal.
- For urgent services, please write "URGENT" at the top of the ARF for priority processing and use the urgent fax number (833) 964-0916. 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.

2. **Fax** the routine and retro Authorization Request Form **and** supporting clinical information to the UM Department at **(888)744-8665**.
3. Fax the urgent Authorization Request Form **and** supporting clinical information to the UM Department at **(833) 964-0916.**
4. Once a determination is made you will receive an approval (or denial) notice via fax. The letter will include the reference number. You can also view authorized services through CCHCA's Provider Portal.

- **When services are denied**, a denial letter is faxed to the requesting provider and the PCP.

5. After rendering the service be sure the claim includes:
   a) The procedure code(s) that was authorized on the ARF 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 ARF.

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Retroactive Authorizations

Utilization Management Department reviews retrospective authorization requests for the following:

1. Services provided were deemed emergency services.
2. Services provided were deemed urgent services.
3. Services involved procedure(s) where a delay would be considered medically inappropriate.
4. Coverage determination was appropriate.
5. Member eligibility information was not available at time of service.
6. Need for additional authorized services were identified during a pre-approved procedure.

A provider may submit a request for a retrospective review to the Utilization Management within ninety (90) calendar days from the date of service.

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; up to 72 hours from the receipt of request. 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 a ARF marked "URGENT" at the top and it will be given priority processing.

Inpatient:

If there is an urgent need for an inpatient authorization, notify our UM Department via fax at **(833) 964-0916.**

- 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 ARF 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 Care Guidelines. 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 Medicare and Commercial Health Plan 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 Care Guidelines. 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.

Inpatient Case Manager Support Physicians in Discharge Planning

The UM Department's Inpatient Case Manageris 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 non-contracted hospital, the Inpatient Case Manager can work with their staff to transfer the patient when appropriate. If the patient discharge is from another facility, the Inpatient Case Manager coordinates with the hospital staff to assure a smooth transition out of the acute care facility.

The Inpatient Case Manager 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	REFERRAL & AUTHORIZATION PROCEDURES
(Use CCHCA Authorization Request Form)	**Outpatient Procedures and Services listed in Section 5.** 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.
Referrals to Out-of-Network Providers **(Use CCHCA Authorization Request Form)**	**Treatment Authorization is required for referral to any "out-of-network" providers.** 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.
Laboratory	**No authorization is necessary if preferred facilities are used.** Refer to the CCHCA Preferred Facilities List. **Treatment Authorization is required for referral to any "out-of-network" providers.** Providers not listed in the CCHCA Preferred

(CCHCA encourages referrals to LabCorp. Please use the appropriate LabCorp order form.)	Facilities List are considered "out-of-network." 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.
Radiology Services	**Treatment Authorization requirements depend on services requested. Refer to the CCHCA Preferred Facilities List for instructions.**
Other Services: Home Care, Physical Therapy, Occupational Therapy, Durable Medical Equipment, Speech Therapy **(Use CCHCA Authorization Request Form)**	**Treatment Authorization required.** 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.
Ambulatory Surgery **(Use CCHCA Authorization Request Form)**	**Treatment Authorization required**. Submit 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 Admissions (Scheduled more than 5 days ahead) **(Use CCHCA Authorization Request Form)**	**Treatment Authorization required**. Submit Authorization Request Form (ARF) 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.
Urgent Authorizations **(Use CCHCA Authorization Request Form)**	Treatment Authorizations may be processed in an expedited manner when marked as "urgent."
Emergency Hospital Admissions	Notify CCHCA's UM Department on the same or next business day. By phone: (415) 216-0088 By fax: (833) 964-0922

Utilization Management Department FAX Number:

(888)744-8665 – Routine Services

(833) 964-0916 – Urgent Services