MHM HEALTHCARE
UTILIZATION MANAGEMENT

TOPIC:	**DATE: 1/31/2025**
Authorization Process	**DATE REVISED:**
	APPROVED BY UMC: signature on file

I PURPOSE

1. To establish a procedure for processing referral/authorization requests for all IPA Members.
2. The Utilization Committee oversees the development and implementation of an effective UM program. This process and structure involve the UM Program's methods for reviewing and authorizing (or denying) requested healthcare services.
3. The process is evaluated, revised and approved annually by the UM Committee and the Board of Directors.

II SCOPE

1. The UM staff work within their scope of practice and in conjunction with the Medical Director or physician designee and the UM Committee to adjudicate authorizations appropriately.
2. A designated senior will have substantial involvement in the authorizations process.
3. Appropriately licensed health professionals will supervise all review decisions.
4. All requests for authorization of services will be processed in accordance with IPA, Health Plan, State and federal regulations.

III POLICY

1. The UM staff will follow IPA's approved UM process/guidelines for the review, authorization, and denial of requested services.
    a. IPA UM processes and guidelines will be in accordance with all Federal, State, NCQA, Health Plan and local regulations.
2. IPA will ensure that all in-network providers are educated on what services require prior authorization from the IPA and the timeframes for decisions.
    a. This may include communication via new provider welcome packets, fax blasts, online portal announcements, or via mail.
3. Authorization and denial determinations will be based on medical necessity or benefit coverage appropriate to the application of approved practice guidelines and criteria.
4. The Medical Director or Physician Reviewer will review and apply appropriate criteria to all modifications and denials following the

correct hierarchy of criteria for line of business.

a.) Documentation of discussion with the Physician Reviewer for remote or telephonic review will consist of a statement by a UM nurse following discussion with the physician reviewer that attributes the denial decision to the IPA Medical Director or Physician reviewer.

b.) In the event of a verbal denial or modification by the Medical Director or Physician Reviewer to the UM Nurse; the Medical Director or Physician Reviewer will have 24 hours to log into the UM portal and countersign the decision, including a statement that he/she attests to his/her review of the case and selection of the rationale/criteria for the determination that was given to the UM nurse. The UM portal will show the user id of the Medical Director or Physician Reviewer that countersigns and attests to the decision using the appropriate criteria.

5. The Medical Director may also sign the weekly/monthly denial log if required to do so by the contracted health plan, including a statement that he/she attests to his/her review of the case and selection of the rationale/criteria for the determination that was given to the UM nurse.
6. Information will be clearly documented and available for review.
7. All Notice of Actions (NOA) and Member approval letters will be written in the Member's preferred language, as indicated by the health plan's eligibility file or by contacting the IPA UM department, including the Non-discrimination LEP, "Your Rights" attachments.
8. Members have a right to request alternate formats for all Notice of Actions (NOA)s, by contacting our UM department or via the Member's health plan Member services department. If this information is provided to the IPA by the health plan's eligibility file, it will by indicated in the IPA's UM system.
    a. The IPA must accommodate the communication needs of all qualified Members with disabilities, including authorized representatives, if requested.
    b. Alternate formats may include Braille, audio format, large print (20 point Arial font), electronic formats (CD) and auxiliary aids.
    c. The IPA must give primary consideration to the Member's request of a particular auxiliary aid or service.
9. IPA to ensure that no authorization shall be rescinded or modified after the provider renders the health care service in good faith for any reason. This includes subsequent rescissions, cancellations or modification of the member's contract or when the delegate did not make an accurate determination of the member's eligibility.
10. IPA to ensure that referring practitioners receive consult reports from the specialists in a timely manner.

IV PROCEDURE

1. Turn-Around-Times (TAT) -All prior authorization requests must adhere to the current Health Industry Collaborative Effort (HICE) and will be adopted

into the UM Program. *See Attached HICE TAT for specifics*.

2. The IPA may need to adhere to stricter guidelines set forth by each individual Health Plan, if applicable.
3. The UM committee (UMC) will discuss, decide and vote on which specialties and diagnosis will fall under direct referral , auto approvals, and services that do not require authorization The IPA will follow the Medi-Cal Provider Manual Preventive Services list and will not require authorization for such services.
    a. Example- Flat plated x-ray or ultrasound are no auth needed.
4. IPA does not prohibit a health care professional from advising or advocating on behalf of a patient.
5. Retrospective Requests- Members will be provided a written notification of the decision within 30 days of receipt of the prior authorization request, regardless of whether the member has financial responsibility or not. This applies to all decision outcomes.

Referral process

1. Requests for authorization of services may be submitted to the UM Department via facsimile, telephone, via our Web based authorization system or verbal request.
2. Authorization requests may be submitted via facsimile or via our web-based system named QuickCap™. Requests submitted via QuickCap™ are automatically date and time stamped upon entry by a requesting provider.
3. Members are allowed to make a verbal request for a standard organizational determination except where the request is for payment.
4. A Member's representative may facilitate care of treatment decisions for a Member who is incapable of doing so because of physical or mental limitations.
5. Paper referrals are entered into QuickCap with the actual date and time that the IPA received the request into our fax system, which creates a tracking number. The paper request is uploaded into QuickCap under document management to show evidence of the actual date/time received.
6. Member eligibility and benefits are checked.
7. The request is reviewed for complete and accurate information to include:
    a. Member Name
    b. Health Plan
    c. ID #
    d. Requesting provider
    e. Requested provider
    f. ICD-10 and CPT codes
    g. Clinical history with supportive medical documentation
    h. Failed treatment to date
    i. Place of service (inpatient,, outpatient, facility)
    j. Estimated LOS for inpatient requests

8. If the medical care a member requires is not available within the IPA or a contracted provider is not available, the Medical Director will instruct the Credentialing Manager to selects prospective providers to execute a LOA/MOE. All pertinent medical information will provided to the Credentialing Manager or designee.
9. For specialist consultation requests, an initial consult and two follow-up visits will be approved.
10. For consults with Pain Management providers, a consult and three follow-up visits will be approved.
11. The UM department will attempt to gather relevant clinical information to support non-behavioral health requests, such as office/hospital records, treatment plans, progress notes from PCP's and specialists, diagnostic studies, lab results or photographs.

Approval Authority

1. Auto approvals: approved by Authorization Coordinators per "Automatic Approvals" policy.
2. UR Nurse Review: all requests not included in the "Automatic Approvals" policy. These requests are reviewed by UR nurses, either LVN or RN, and are reviewed with approved medical necessity criteria and benefit and coverage tables per governing agency and health plan policy. Any requests that cannot be approved by a UR nurse are given to the Physician Reviewer / Medical Director for review.
3. Physician Review: all requests that cannot be approved for any reason including benefit, coverage or medical necessity by a UR nurse. Requests submitted as Urgent are forwarded to the Medical Reviewer within 3 hours of the request.
4. Authorizations Received with inadequate supportive medical information- Medi-Connect, Medi-Cal Members

    a. When authorization requests are received which have inadequate medical information affecting the ability to render a decision, there must be three (3) documented outreach attempts to collect the missing information. Every effort is made to make an initial request within a few hours of receipt of the request, but in no case shall the initial attempt be made later than one business day unless there are extenuating circumstances. These requests shall be date and time stamped, with documentation of the reviewer's name, title, and level of licensing as applicable. The request will state exactly what medical information is missing and requested, based upon the criteria used to make a decision for the service requested. The request will be forwarded to the Physician Reviewer if the needed documentation was received but did not meet the

criteria for the service requested, or if no additional information is received. The Physician Reviewer will sign all delay / deferred letters.

b. A daily report is used to track all delayed or deferred authorizations in the system by the UM Manager or Authorization Supervisor
c. The Delay Letters states the information needed to make a decision and is sent to the requesting provider and the member and shall include the date by which a decision will be made, which is within 14 days of the initial request.
d. The Delay letter shall also state if an Expert Reviewer is required and the type
e. The IPA shall make at least three (3) documented attempts to procure pertinent medical information which is needed in order to make a decision

5. Authorizations Received with inadequate supportive medical information- Medicare Advantage Members
    a. When authorization requests are received which have inadequate medical information affecting the ability to render a decision, there must be three (3) documented outreach attempts to collect the missing information. Every effort is made to make an initial request within a few hours of receipt of the request, but in no case shall the initial attempt be made later than one business day unless there are extenuating circumstances. These requests shall be date and time stamped, with documentation of the reviewers name, title, and level of licensing as applicable. The request will state exactly what medical information is missing and requested, based upon the criteria used to make a decision for the service requested. The request will be forwarded to the Physician Reviewer if the needed documentation was received but did not meet the criteria for the service requested, or if no additional information is received. The Physician Reviewer will sign all delay / deferred letters.
    b. A daily report is used to track all delayed or deferred authorizations in the system by the UM Manager or Authorization Supervisor

D. Medicare Advantage Members

1. Procedural Defects – Medicare Advantage/ SNP Member

    a. When the Member or Provider fails to follow the IPA procedures of requesting an authorization, the IPA must notify the member or provider of the failure and the proper procedures to follow within 5 calendar days for non-urgent requests and 24 hours for urgent requests. The notification

may be oral, unless written notice is requested by the member or provider.

E. Crystal report writer is used in conjunction with QuickCap™ to track authorizations in all status types including requested and deferred and by type such as Urgent or Routine. This same information is available to physician offices that have access to our online portal.

F. Authorization review reports are run daily and are refreshed throughout the day for follow-up and determination of compliance with ICE TAT standards by Authorizations staff members.

G. Previous authorizations in the system are reviewed to prevent duplication of services and assess prior treatment.

H. The request is submitted to the designated reviewer.

1. The reviewer makes a determination based on approved practice guidelines and criteria.
2. Complex cases are referred to the UM Committee.
3. Board certified physicians from appropriate specialty areas assist in making determination of medical appropriateness.
4. Case Management and concurrent review cases as well as CCS eligible conditions are referred to the appropriate staff.
5. Only the Physician Reviewer / Medical Director may deny services.
6. Providers/practitioners and members are notified by IPA of all approved and denied requests for services in accordance with the Authorization HICE TAT P & P.
7. Practitioners are responsible for maintaining a system to track the authorization/referral process. This system must include the member name, date of the referral, name of provider referred to, type of service (lab, tests, consult), appointment of testing date or consult, the date the report or result was received, the date the physician reviewed the result/report and the date the patient was notified of the result. Compliance with this process is monitored during the recredentialing medical record review process.
8. *S*killed therapy service requests (SNF, HH, OT/PT/ST) are not denied based on the absence of potential for improvement or restoration. Requests are reviewed based on member's medical condition and requirement of skilled care that is reasonable and necessary to prevent or slow further deterioration.
9. Reconstructive /Cosmetic surgery will be covered, per health plan guidelines, when used to correct or repair abnormal structures of the body caused by: congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to either improve function or create a normal appearance (to the extent possible).

I. Expedited Initial Organizational Determinations – Member/Enrollee Request

1. An enrollee may request services directly of the Medicare

Advantage Plan or the IPA. The IPA accept requests for initial organization determinations directly from enrollees or from the Plan on behalf of the enrollee.

2. The request may be made orally or in writing
3. Enrollee calls will be directed to a UM Coordinator who will begin the adjudication process by entering the enrollee's request into the Utilization system documenting date, time and requested services. The UM coordinator will notify the IPA Nurse Reviewer either orally or by sending the request to the appropriate Nurse Review Queue within 4 hours of the request.
4. The UM coordinator will contact the enrollee's PCP to document pertinent facts and to request pertinent medical records.
3. Requests for payment must be made in writing (unless the MA organization or entity responsible for making the determination has implemented a voluntary policy of accepting verbal payment requests).

J. Expediting certain organization determinations

1 Requests for expedited determination - An enrollee or a physician (regardless of whether the physician is affiliated with the MA organization) may request that an MA organization expedite an organization determination involved in the issues described below. (This does not include requests for payment of services already furnished.)

2. How to make a request.

(a) To ask for an expedited determination, an enrollee or a physician must submit an oral or written request directly to the MA organization or, if applicable, to the entity responsible for making the determination, as directed by the MA organization. A physician may provide oral or written support for a request for an expedited determination.

3. Actions that are organization determinations

a. The MA organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization.

b. Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment

4. The turn-around time (TAT) frames for standard and urgent initial organization determinations starts at the time the member contacts either the Plan or the IPA.
5. The IPA will collaborate with the health plan on requests for

referrals or authorization of services when an enrollee contacts the Plan.

6. The IPA will perform determination processes for those services for which it is delegated, including timely decisions and notifications.

E. Delays

1. Extensions will not be used to pend organization determinations while awaiting medical records from contracted providers. Information from contracted providers must be provided within the allotted timeframe. The IPA Medical Director will be contacted to assist in facilitating the provision of medical records if medical records do not appear to be forthcoming.
2. Extension will only be allowed at member request or if the provider/organization justifies a need for additional information and must demonstrate that the delay is in the best interest of the member.
3. Members will be given written notification of a delay as soon as it is determined that additional information is needed, or within the appropriate timeframe for the urgency of the request, whichever comes first. Timely notification will include information required to make a determination and a planned date of decision.
4. The IPA will adhere to the approved CMS Turn-Around-Time grid developed and published by the Industry Collaborative Effort (ICE) including information regarding members' right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf.
5. Information mailed to Medicare Advantages beneficiaries (prospective or enrolled) should include one of the three statements on any envelope or the mailing itself (if no envelopes are being sent) that they are sending to Medicare beneficiaries regardless of the materials inside of the envelope. One of the three statements on the outside of the envelope or mailing itself will be used in accordance with the best fit the information being sent to the Medicare beneficiary which are:

   a Advertising pieces – "This is an advertisement"

   b.Plan information – "Important plan information"

   c. Health – "Health or wellness or prevention information"

   d.Non-health or non-plan information - "Non-health or non-plan related information"
6. For all correspondence mailed to Medicare Advantage enrollees, most IPA mail meets the category of "Plan Information". Pre-printed envelopes will be used that include the phrase "Important Plan Information" in a 12 point font on the front of the envelope or the mailing itself (if no envelope is being sent) The IPA envelopes will include this statement below the IPA return address.
7. **Commercial line of business**

a. Benefit or contractual clarifications are not reasons to delay/pend a request.
b. If IPA cannot make a determination for non-urgent prospective or continued stay reviews within the required time frames due to not receiving all of the requested necessary information, delegate must immediately notify the health care provider and the covered person in writing. Must send such notification upon the expiration of the required five (5) business day time frame or as soon as delegate become aware that they will not be able to meet the required five (5) business day time frame, whichever occurs first. The notification must specify the information requested, but not received, and the anticipated date on which a prospective or continued stay review determination may be rendered. Upon receipt of all necessary information, delegate must render a prospective or continued stay review determination within the required five (5) business day time frames.
c. Notices sent to Members and practitioners will include the following:

1). Information was requested but not received
2). Consultation by an expert reviewer is required
3). Additional examinations or tests are required.
4). Time frame for submitting the information
5). Expected date of decision
6). Type of expert reviewer required, if applicable

F. Documentation and Coordination of Care

1. When referring a member for specialty services, practitioners must follow the IPA guidelines and shall also:

   a. Note the referral in the patient's medical record
   b. Forward copies of medical records or test results to the specialist
   c. Coordinate with the attending physician when specialist consultations and services are needed during an inpatient stay (N/A if hospitalists are used)

G. Member & Provider notification of approved authorizations in accordance with ICE TAT grids

1. Medicare Advantage Routine

   a. Fully favorable Medicare Advantage Routine Authorization notices are mailed within 24 hours of the decision via US Mail. – See Approved Authorization Letter Mailing Policy

2. Medicare Advantage Expedited Initial Organizational Determinations

2. Oral or written notice is given to the member and provider within 72 hours of receipt of request.
    a. Staff shall document date and time oral notice is given and to whom it was given.
    b. If only a written notice is given, it shall be received by member and provider within 72 hours of receipt of request.

3. Commercial Decision Making and Member/Provider Notifications

    a. Follow the current ICE UM Timeliness Standards for Commercial HMO-California for the following:
        1. Urgent Pre-Service
        2. Urgent Pre-Service extension needed
        3. Urgent Concurrent
        4. Standing referrals to Specialists/ Specialty Care Centers
        5. Non-Urgent Pre-service
        6. Non-Urgent Pre-Service extension needed
        7. Post Service
        8. Post Service extension needed
        9. Translation Requests for Non-Standard Vital Documents
        10. Prescription Drugs

7. Returned Written Authorizations

    a. Member addresses are provided electronically in the electronic Eligibility Files provided by the health plans
    b. Mail returned for any reason, including an invalid address, will be opened by Mail Room staff within 48 hours of receipt of the returned letter.
    c. Mail Room staff shall telephone members using the telephone number listed in the Member File to request updated/valid address.
    d. If staff are unable to reach the member via telephone, the staff will contact the member's PCP to request the member's address of record.
        1. Once a valid address is obtained, the returned approval notice will then be mailed to the member along with a "Member Notice of Invalid Address" letter. See attachment "A"
        2. Contact with the member shall be attempted within 24 hours of receipt of an Urgent or EOD request.

H. Provider Access During a Federal Disaster or other Public Health Emergency Declaration

1. The Emergency Disaster policy and plan begins with a Declaration of Federal or local determination

2. Access continues for 30 days from the date of the original designation
3. Allows Part A, B & C benefits at non-network facilities
4. Waives in full requirement for “gatekeeper” referrals
5. Temporarily reduces out-of-plan approved costs to in-network cost sharing amounts
6. Waives the 30-day notification requirement to enrollees as long as all of the changes benefit the enrollee (Waiving authorizations and reduction of cost sharing)

I. Approval Notification for UM determinations is provided timely via Telephone, Facsimile or in writing to the provider, facility and member.

J. Written Notices are provided upon request

K. Notices shall include the referral number or the pre-certification number.

L. Notices for continued hospitalization or services includes the number of extended days, the net anticipated review point, the new total number of days approved and the date of admission or onset of services.